Grow. Be **Better.** Become **More.**

2765 S. ALBRIGHT ROAD
KOKOMO, IN 46902

P: 765.450.9214
www.familypiece.com

Client Information Form (rev. 2/20/20)

Today's Date:____________________

CLIENT'S INFORMATION:

Name (last, first, middle): ________________________________ Date of Birth:____________ Age:____ Sex:____

Marital Status:__________ Spouse:____________________________ Spouse's Phone______________________

Address: _____________________________________ City:_________________ State: _____ Zip: _______

Email:____

Preferred Phone: (_____)_________________ (circle one) Mobile Home Work

May we ☐ contact you ☐ leave a voice message?

Emergency Contact: __________________ Relationship:_______________ Phone: (______)_________________

Referred by:_______________________________ Occupation/Employer:_______________________________

Faith preference: _____________________________Home Church:_____________________________________

Primary Physician:____

RESPONSIBLE PARTY (if client is a minor, and for billing purposes):

Name (last, first, middle): ________________________________ Date of Birth:____________ Age:____ Sex:____

Relationship to client: ___________________________

Address: _____________________________________ City:_________________ State: _____ Zip: _______

Email:____

Preferred Phone: (_____)_________________ (circle one) Mobile Home Work

May we ☐ contact you ☐ leave a voice message?

Insurance Information

Primary Insurance Company Name: ___________________________ Policy ID Number:____________________

Employer:___________________________________ Group Number ______________________

Name of Insured__________________________ D.O.B.________________ Relationship to Patient____________

Secondary Insurance Company Name _________________________________ Policy ID Number______________

Employer:___________________________________ Group Number ______________________

Name of Insured__________________________ D.O.B.________________ Relationship to Patient____________

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorized the release of any information regarding me/my child's condition or treatment to my insurance company.

SIGNED: ____________________________________ DATE:_______________________

(client, or parent if client is a minor)

Grow. Be Better. Become More.

2765 S. ALBRIGHT ROAD
KOKOMO, IN 46902

P: 765.450.9214
www.familypiece.com

Counselor & Client Services Agreement rev. 3/9/20

Welcome to our practice! This service agreement contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). This federal law provides you privacy protections and certain client rights. We can discuss any questions you have about our practices and procedures at any time.

Your signature on this document establishes an agreement between us that ends when you reach your goals and communicate that with us, or when choose to end your work with us. Termination is discussed in detail later in this document.

PSYCHOLOGICAL SERVICES
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, as well as the particular problems you are experiencing. There are many different methods our clinicians may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, therapy is team-work, it is collaborative; and it *calls for a very active effort on your part.* In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience temporary uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. The content of psychotherapy sessions may impact relationships in adverse ways when you bring a spouse, family member, or other into the session with you. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. Experiences of therapy vary depending on the personalities of the therapist and client(s) and the particular problems the client(s) is experiencing. If you have questions about procedures at FPC, you should discuss them with us whenever they arise. If your doubts persist, We will be happy to help you set up a meeting with another mental health professional, as our goal is your health and growth.

MEETINGS
Your first two to four sessions will involve an evaluation of your needs. During this time, you and your therapist can both decide if your counselor is the best person to provide the services you need in order to meet your treatment goals. By the end of the evaluation, your counselor will be able to offer you some first impressions of what your work might include and will work with you to develop a treatment plan. If you decide to

continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your counselor. If psychotherapy is begun, your counselor will usually recommend you schedule one to three 45 minute sessions per week depending on your goals. *Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 business hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.*

PROFESSIONAL FEES

The first 2-4 initial evaluation sessions fees are $130. Our regular counseling session fee is $90. Clients sometimes ask for other professional services such as longer sessions, or full day or multi day intensives. Cost for these services as well as other professional, administrative, or court related services are detailed in our Financial Policies document. Please note that many of the services we provide are not billable to insurance.

CONTACTING YOUR COUNSELOR

Due to our varied work schedules and the improbability of your counselor answering the phone when with a client, your counselor is often not immediately available by telephone. When therapists are unavailable, the telephone is answered either by our secretaries who know where to reach the clinicians, or by voice mail that is monitored frequently. Our staff are in the office Monday through Thursday from 9am to 5pm to answer the phones. We are also open evenings 5-8pm Monday through Wednesday. Your counselor will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach your counselor and feel that you can't wait for the return call, contact your family physician or the nearest emergency room and ask for the therapist or psychiatrist on call. If you are experiencing a life-threatening emergency, call 911. If your counselor will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNIICATION

Family Piece Counseling occasionally uses email and text messaging to exchange information efficiently for the benefit of our patients. We recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission. If you prefer not to authorized the use of email and/or text messaging that contains your health information, it will not affect your health care in any way. We will continue to use U.S. Mail or telephone to communicate with you.

VIDEO AND AUDIO RECORDING SESSIONS

As a primary tool in ongoing commitment to professional development, and in order to augment your therapy work, we use video recording feedback as part of therapy sessions. This means that we may ask to video record you during specific dialogues or exercises, or during entire sessions. At times, we will play back these recordings in sessions to help you see patterns of thinking, behavior, and when applicable,

interactions between you and your partner. By viewing video recording in sessions, it allows us to “stop action” and process how you might approach problems or conflicts in more productive ways. It also allows you to witness your progress as you attain your goals / as your relationship become more satisfying to both of you.

In addition to in-session use, we may wish to use recordings to receive consultation from subject matter experts or clinical supervision. This may occur during the time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process, your name will be kept confidential. The recordings are not part of your clinical record and will be used for no other purpose without your written permission and they will be permanently deleted when they are no longer needed for these purposes.

The recordings are the property of your therapist and will remain solely in the professional’s possession during the course of your therapy. Copies may be sent to subject matter experts for the purpose noted above. Should you wish to review these tapes for any reason, we will arrange a session to do so. These materials will be securely stored at all times.

You will be asked to accept the conditions of this statement and give your permission to have your therapy sessions video/audio recorded on our consent form. You may revoke this permission at any time.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a counselor. In most situations, we can only release information about your treatment to others if you sign a written Release of Information (ROI) form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. In either case we provide only the minimum information necessary. Your signature on this Agreement provides advance consent for the following activities:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Counselor's Policies and Practices to Protect the Privacy of Your Health Information).
- If a client seriously threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the client to the client or others, or there is a probability of immediate mental or emotional injury to the client.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by counselor-client privilege. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or

contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a client files an insurance, worker's compensation claim, or third party payment claim we must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

Additionally, there are some situations (listed below) in which we may be **permitted or required to disclose information or take action without either your consent or authorization**. Although these situations are unusual in our practice; we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, we will make every effort, where appropriate, to fully discuss it with you before taking any action. We will limit information in any disclosure to the minimum necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

The following is a list of exceptions to counselor-client privilege in Indiana. IC 25-23.6-6-1

(1) In a criminal proceeding involving a homicide if the disclosure relates directly to the fact or immediate circumstances of the homicide.
(2) If the communication reveals the contemplation or commission of a crime or a serious harmful act.
(3) If: (A) the client is an unemancipated minor or an adult adjudicated to be incompetent; and
(B) the information communicated to the counselor indicates the client was the victim of abuse or a crime.
(4) In a proceeding to determine mental competency, or a proceeding in which a defense of mental incompetency is raised.
(5) In a civil or criminal malpractice action against the counselor.
(6) If the counselor has the express consent of:
(A) the client; or
(B) in the case of a client's death or disability, the express consent of the client's legal representative.
(7) To a physician if the physician is licensed under IC 25-22.5 and has established a physician-patient relationship with the client.
(8) Circumstances under which privileged communication is abrogated under Indiana law.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in one (and sometimes two) set(s) of professional records. The primary set of records constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing (charges apply). The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your Clinical Record, you have a right of review, which we will discuss with you upon your request.

In addition, we may also keep a set of Psychotherapy Notes. These Notes are for your counselor's own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, your counselor's analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to your counselor that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal.

MASTER'S LEVEL INTERN PROVIDERS

Family Piece participates in the broader community effort to develop and train effective counselors. We have agreed to contribute to the training of interns who are wanting to learn more about the helping process. Our interns have received advanced training at a master's level university program and are expected to volunteer their time in service to the community. In addition to their specialized training they often have excellent life experience that may benefit you. Their service is offered at no cost. This is a voluntary opportunity and you are in no way obligated or expected to participate. Further, you may change your level of participation at any time.

PROVIDERS WITH ASSOCIATE LICENSURE

As part of our commitment to excellence we have a very robust standard of supervision for providers who are working toward full licensure while having been awarded a temporary and/or Associate License to practice by the state of Indiana. Providers working toward full licensure are supervised by fully credentialed supervisors. In the case that a supervisor is not fully credentialed as a supervisor, but is actively working toward this certification, you can expect that supervisor to be also actively engaged with a supervisor mentor.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that your counselor amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and the HIPPA information form.

MINORS AND PARENTS

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in individual psychotherapy is often crucial to successful progress, particularly with teenagers, it is our practice to provide parents only with general information about the progress of the child's treatment. If requested, we will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the counselor feels that the child is in danger or is a danger to someone else, in which case, the counselor will notify the parents of the concern. This is our policy unless the threat to the child is a parent, in which case we may not notify the parent if doing so is determined to create increased safety risk for the child. Before giving parents any specific information, the counselor will discuss the matter with the child, if possible, and we will do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

TERMINATION OF SERVICES

Ending relationships after successful treatment can itself develop positive growth. Therefore, we believe finishing our work with an active and intentional termination process can be valuable for you. Oftentimes, the appropriate length of the termination depends on the length and intensity of the treatment. For us, termination means that you are no longer an active client. Termination does not mean you will not initiate treatment again with us. We are here for you and many people find it helpful to get our help through many different seasons of their life. However, we close out each episode of treatment to keep an accurate idea of our case loads.

Other reasons for termination include: determinations that psychotherapy is not being effectively used, times when a client is not actively engaged in treatment, or in cases of

default on payment. We may terminate treatment if clients no-show for a session and do not respond to our attempts to contact. We may also terminate when a client does not schedule/attend one session within a 2 month period without an agreed upon plan for such absence. Generally we will not terminate the therapeutic relationship of an actively engaged client without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

WELCOME TO OUR PRACTICE. WE LOOK FORWARD TO WORKING WITH YOU!

2765 S. ALBRIGHT ROAD
KOKOMO, IN 46902

P: 765.450.9214
www.familypiece.com

Financial Policies rev. (2/20/20)

You are ultimately responsible for your Family Piece Counseling bill. If you have insurance coverage, we will help you by filing claims, and providing whatever reasonable information your insurance company requests from us. However, please be advised that working with your insurance company is a courtesy service provided by Family Piece Counseling, and we cannot guarantee that your insurance company will pay. If your insurance does not pay us for any reason, you will be responsible for your remaining balance.

If you and your therapist use telehealth assisted therapy please note that many (but not all) insurance companies cover costs for services provided telehealth. If you plan to use insurance to cover costs for services, it is your responsibility to check with your insurance company to ensure they cover telehealth services.

Payment

Payment and co-payment for counseling is due at the time of service. The only exception to this is Tele-health sessions. We require payment for Tele-health sessions two days in advance. Please make checks payable to Family Piece Counseling. We also accept many HSA's, as well as payment through Visa, MasterCard, American Express and Discover.

45 Minute Sessions and Extensions

If there are any questions about fees, they can be discussed with our administrative team. Fees are generally quoted for a 45-minute session. At times you and your therapist may find value in extending the session(s). Extensions are billed at $25 per 15 minutes and are not reimbursed by insurance. Extensions will not be submitted to insurance. Instead, extensions are billed directly to the account responsible.

Costs for ninety minute, half day, whole day, or multiple day sessions are available upon request. Please note that insurance will generally only reimburse 45 minutes of counseling per day. However, many people - **especially couples** value the benefits of longer sessions. In these cases we bill insurance for the first 45 minutes and the remainder is paid directly by the client. For specific financial details, you should speak with our front office.

Cancellation Policy

Your appointment time has been reserved specifically for you. Once your appointment is scheduled, you will be financially responsible for it unless you provide 24 business hours notice of cancellation. It is important to note that insurance companies do not provide reimbursement for sessions you do not show up for, so your counselor is not paid when you do not come to your session. However, because we know that emergencies do come up occasionally at the last minute (sudden illness, car troubles, etc.), we'll generally forgive two late cancellations or no-shows per twelve-month period.

After your two penalty-free late cancellations or no-shows, you will be billed $50 for your next two late cancellations or no-shows, and then $100 for every additional session you cancel without 24 hours notice and every session you do not show up for, regardless of the reason.

Our Fees

- Many services we provide are not covered by insurance. Most (if not all) insurance companies pay only the cost of services related to the treatment of diagnosable mental health disorders. Please refer to section on “Insurance Reimbursement” section of the Counselor and Client Service Agreement.
- We charge $130 the first 2-4 evaluation sessions, and $90 for each session thereafter.
- Extensions of session time are billed at $25 per 15 minutes and are not reimbursed by insurance.
- Prices for 90 min., half, whole, or multiple day sessions are available upon request. Extended or intensive sessions such as these are not reimbursed by insurance.
- Telehealth sessions are billed at the same rates as in person sessions and coverage for these services is unique to each insurance company.
- Consultative phone calls with clients, individual, or other professionals lasting longer than 10 minutes are billed $25 per 15 minutes. Similar to telehealth sessions these services are covered by some insurance providers and not others.
- Letters written to doctors, employers or EAP representatives will cost $25 and up (depending on complexity and time involved). These are billed directly to the client.
- Services necessitating travel are billed a separate travel charge of $75/hr.
- Formal Assessments require additional fees that will be clearly explained in advance.
- Cancelled appointments without 24 hr notice are billed directly to the client. See above.
- Returned checks will be assessed a fee of $35.
- Printing of clinical records is provided with a a $25 service fee.
- Services related to legal proceedings are described in detail below and must be paid in advance of the service.

Services Related to Legal Proceedings

If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time and costs, including preparation, consultation, and transportation costs. Because of the complexity of legal involvement, we charge $150 per hour for preparation, and report writing. These charges must be paid in full before a service is performed or a document/report is released. We charge $75/hr of travel. Clients and/or attorneys will pay $250 per hour for courtroom testimony and/or legal deposition services. A minimum charge of four (4) hours will apply, payable in advance, when honoring a subpoena or court order and/or when providing testimony in court, regardless of whether or not the therapist actually testifies. A minimum charge of two (2) hours will apply, also payable in advance, when honoring a subpoena for a deposition. Should any subpoena request provide late notice (less than three weeks), an additional charge of $300 will be billed the client and/or attorney to cover losses related to late/crisis re-scheduling.

Scholarships

Scholarships are available to qualified private pay applicants. Scholarships are given based on financial need according to yearly household income, number of dependents, and need. Please ask our staff for a scholarship application if you are interested.

Family Piece Counseling

Grow. Be Better. Become More.

2765 S. ALBRIGHT ROAD
KOKOMO, IN 46902

P: 765.450.9214
www.familypiece.com

HIPAA Information (rev. 2/20/20)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations: As a Counselor, I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

To help clarify these terms, here are some definitions:

"**PHI**": refers to information in your health record that could identify you. "**Treatment, Payment and Health Care Operations**": *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another Counselor. *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

II. Uses and Disclosures Requiring Authorization: I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization: I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If, in my professional capacity, I have reasonable cause to suspect that a child is abused or maltreated I must report such abuse or maltreatment to the statewide child protective services agency, or the local law enforcement.
- Health Oversight: If there is an inquiry or complaint about my professional conduct to the State Board for Psychology, I must furnish to the Indiana State Board, your confidential mental health records relevant to this inquiry.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records

- thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.
- Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.
- Worker's Compensation: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Client's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

V. Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide individuals with a revised notice by mail.

VI. Complaints:

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may talk to me directly about it or you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VII. Effective Date: This notice will go into effect on February 20, 2020.

End of HIPAA Notice

Family Piece Counseling

Grow. Be Better. Become More.
2765 S. ALBRIGHT ROAD
KOKOMO, IN 46902
P: 765.450.9214
www.familypiece.com

Consent Form rev 3/9/20

Your initials and signature below indicate you have read the Counselor & Client Services Agreement (rev. 2/20/20) and agree to its terms. Your signature below also serves as an acknowledgement that you have read our HIPPA Information document described in the agreement.

Please Initial

____ I understand counseling is a cooperative effort between myself and my counselor. I agree to my counselor aware of my needs and goals for treatment.
____ I understand I am consenting to mental health services that my counselor is qualified to provide within their scope of professional (or his/her supervisor's) license, certification, and training.
____ I understand my treatment is confidential as described in the Service Agreement and HIPPA Information.
____ I authorize FPC to release necessary medical information to appropriate third parties for reimbursement purposes and/or to persons authorized to conduct service utilization reviews.
____ I authorize my counselor to contact my Primary Care Physician (listed on the Patient Information Form) to coordinate services when necessary.
____ I understand and agree: I am personally and fully responsible to pay for all services rendered.
____ I understand that sessions are 45 min in length. Additional charges are billed in 15 min increments and are generally not covered by insurance. More information is provided in our Financial Policy document.
____ I understand that once an appointment is scheduled I am responsible to pay the session whether or not I attend unless providing at least a 24 hour notice of cancellation.
____ I understand that my insurance may pay for the treatment of diagnosable disorders and that I am responsible for the cost of treatment where insurance does not cover.
____ I understand that audio and video recording are tools that may be used in my treatment to improve outcomes. These recordings will be managed confidentially and will be permanently deleted when no longer of use.
____ I have read the Counselor and Client Service Agreement and agree to it's terms.
____ I have read the HIPPA Information document

Please Choose:

☐ I consent to occasional use of email/text messages by FPC when doing so is necessary/beneficial to me.
☐ I do not authorize the use of email or text messaging.

Clients of Associate Licensed Therapists must also provide their initials below to accept the following terms

Please Initial

____ I understand my counselor is supervised by a licensed allied mental health professional.
____ My therapist is receiving supervision by a clinician who is also being mentored as a supervisor.
____ As a tool in on-going training and improvement, supervisory techniques such as video recording, audio recording, in-session live supervision, and psychometric assessment instruments may be used.

______________________________ ______________________________/__________
Client's Printed Name Client's Signature / Date

______________________________/__________
Parent Signature, if client is under 18 years old / Date

Family Piece Counseling

Grow. Be Better. Become More.

2765 S. ALBRIGHT ROAD
KOKOMO, IN 46902

P: 765.450.9214
www.familypiece.com

INFORMED CONSENT AGREEMENT AND TECHNOLOGY-ASSISTED CLIENT SERVICES AGREEMENT

(rev 2/20/20)

RISK AND BENEFITS OF TECHNOLOGY-ASSISTED SERVICES

As described previously in our Counselor-Client Agreement there risks and benefits associated with counseling or relational therapy. Here we focus specifically on the possible risks and benefits to technology assisted therapy.

Potential **risks** include:

1. I, as your therapist, cannot take certain immediate actions in cases of emergency
2. Sometimes technology fails
3. Even when the best precautions are taken to preserve privacy and confidentiality, We cannot 100% guarantee that unauthorized persons will not have some access to our online conversations (for example, if someone walks into your home unannounced).

Potential **benefits** include:

1. Ability to supplement weekly in person therapy
2. Ability to have joint sessions when partners are in different locations
3. Fewer obstacles to treatment (i.e. not leaving the comfort and privacy of your home, less need to arrange childcare, less time spent in travel)

GOODNESS OF FIT

We do not recommend tele-health to suicidal clients or to couples who experience domestic violence. There are other considerations that may or may not make Tele-health a good fit. The therapist will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for technology-assisted services.

MEETINGS

Tele-health sessions are typically 4*5 minutes* in length for individual, family, or couple sessions. However, we can accommodate longer sessions. Couples, families, or groups especially benefit and many times prefer longer sessions. As professionals we also see longer sessions very productive. We are able to schedule 90 min sessions at a frequency that makes the most sense depending on the severity of problems. Very often couples value and benefit tremendously from marathon or intensive sessions. These can be provided in half, whole, or multi-day session as desired.

Each meeting will begin with a start-up protocol which includes:

- Client providing a phone number they can be reached in case of internet failure
- Current address/location of client in case of emergency
- Counselor and Client confirm that location is secure and private.

In cases of technology failure during a session due to poor connectivity, loss of power, or any other reason, the therapist will call the client at their provided phone number and will make arrangements to either complete the session via phone or reschedule for another time.

PAYMENT and SCHEDULING

Tele-therapy is currently offered ONLY on Saturday mornings. We require appointments to be paid in full prior to the tele-therapy session. This can be done by calling our office @ (765) 450-9214. Payment must be received by noon on Thursday. Once payment is made you will be given a confirmation number.

Your appointment time has been reserved specifically for you. Once your appointment is scheduled, you will be financially responsible for it unless you provide 24 business hours notice of cancellation.

If you do have insurance, your insurance plan will determine the cost of any co-pays and fees. Many (but not all) insurance companies cover costs for services provided telehealth. If you plan to use insurance to cover costs for services, it is your responsibility to check with your insurance company to ensure they cover telehealth services. You are directly responsible for any fees insurance does not cover.

You will not be seen by your therapist when your account is in arrears two sessions unless some prior arrangement has been made between yourself and your therapist.

CONFIDENTIALITY OF MESSAGING: TEXT, EMAILS, AND VOICEMAIL

While we work to ensure the privacy of information we receive, we cannot guarantee the confidentiality of any form of communication through digital/electronic media, including text messages, voicemail, and email. While the use of these platforms are sometimes necessary for distance-counseling procedures such as scheduling appointments, we request that you do not use these digital mediums to discuss therapeutic content. We also cannot guarantee immediate response. We will NOT respond to emergency requests through text messaging or emails; once we see your message/email, we will call you over the phone, and we will set up a video-conferencing session. If there is an emergency, please call 911 or go to the nearest emergency room. We will not respond to text messages sent while intoxicated.

Knowing these limits, I give my consent for communication for scheduling and/or cancellation purposes via:

Email ________ (**initial**) Voicemail: __________ (**initial**) Text Message: __________ (**initial**)

TELEPHONE AVAILABILITY

If you need to contact me between sessions, please leave a message through the main office. We are often not immediately available; however, we will make every effort to return your call within 24 hours. If you are wanting to notify us of a scheduling change, please call our office and leave a voice message if no one is available. Our office phone number is (765) 450-9214.

If we are unavailable and an emergency or relationship crisis arises, you should visit your local emergency room, call 911, or call the National Suicide Prevention Hotline (if your crisis pertains to suicidality). Also, if you are concerned about your physical safety within your relationship with your spouse/partner, you should have the number of your local domestic violence agency on hand.

SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking sites (Facebook, Twitter, LinkedIn, Tumblr, SnapChat, Instagram, Pinterest, Kik, etc.) for a minimum of 2 years after the end of our professional therapeutic contract, and we reserve the right to not accept friend/contact requests from former clients even after that time. We believe adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

TERMINATION

We consider the professional relationship discontinued, and technology-assisted services will be terminated if you no-show our scheduled appointments twice, or you cancel scheduled sessions repeatedly, unless other arrangements have been made in advance.

CLIENT AUTHORIZATION

By signing this document, you agree you understand the risks associated with technology assisted services, consent to online treatment, and do not hold the therapist liable for breaches of privacy beyond the therapist's control.

I, (print full name) ____, the client, have read and agree to the terms outlined in this Client Services and Informed Consent Agreement and give consent for technology-assisted services. Further, I understand that Family Piece Counseling will abide by the above mentioned policies, procedures, and techniques in providing my treatment and training its therapists.

____________________________________ ______________________

Client Signature Date

CONSENT FOR A MINOR

If the client is a minor child, then as parent, legal guardian, or managing conservator of this minor child, I do hereby authorize Family Piece Counseling to provide technology-assisted therapeutic services and agree to the terms of this agreement for my child.

____________________________________ ______________________

Parent or Guardian Signature Date

For Office Use Only:
Client ID _______

Today's Date: ___________

Confidential Pretreatment Questionnaire

This intake form assists me in gathering information in order to provide the most comprehensive care that I can for you. You do not have to answer any question, but the more information you provide, the better I can help you. All information will be kept confidential in accordance with our privacy policies.

Please bring this sheet with you on your next appointment. If you need more space, you may write on the back of the sheets.

Name: ____________________________________Age:_____ Race:__________ Gender:_____
Marital Status: ___________________

1. Please identify your top 3-5 goals that you would like to address in counseling:
   - 1
   - 2
   - 3
   - 4
   - 5

2. What is the reason you are seeking counseling support now versus another time? ________________
____
____

3. What are the biggest obstacles that you face? ____
____
____

4. Please list the greatest stressors you are experiencing: _____________________________________
____
____

5. Please list who and what are your greatest supports: ____
____
____

6. Please describe how the concerns that bring you in for counseling are affecting you and those closest to you. (ex: emotionally, relationally, financially, sleeping, eating, concentration, etc.)_____________
____
____
____
____

Today's Date: ___________

Confidential Pretreatment Questionnaire

7. How long have you had the concerns that are bringing you to counseling? When did the problem start____
____

8. What have you tried to solve you concerns in the past? ______________________________________
____

9. What successes have you had in solving your concerns? ______________________________________
____
____

10. If you have you received professional support or treatment for these or any related goals in the past please tell complete the following for each incident: a.)Who did you see, b.) how long did you see them, c.)was treatment successful? ______________________________________
____
____
____
____

11. If applicable, please list any emotional or mental diagnosis you or anyone in your family has been given. ____
____
____

12. Have you ever experienced physical, verbal, or sexual abuse? □ **Yes** □ **No**
13. Have you witnessed violence, or been in a dangerous situation? □ **Yes** □ **No**
14. Has there ever been a time when someone touched or treated you inappropriately? □ **Yes** □ **No**
15. Do you currently have concerns about your safety: □ **Yes** □ **No**
16. Do you currently have thoughts about hurting or harming yourself or another? □ **Yes** □ **No**
17. Have you or anyone in your family and/or close friends ever made a suicide attempt? □ **Yes** □ **No**
18. Have you or anyone in your family used or abused alcohol, prescription, or illicit drugs? □ **Yes** □ **No**
19. Have you ever been arrested or experienced legal problems □ **Yes** □ **No**
20. Have you ever experienced behaviors within yourself that you wanted to stop, and that despite causing serious problems you were unable to stop? □ **Yes** □ **No**
18. In the past six months have you felt depressed? □ **Yes** □ **No**
    If so, when and for how long? ______________________________________
19. In the past six months have you felt very happy? □ **Yes** □ **No**
    If so, when and for how long? ______________________________________

20. Have you ever had any experience that was so frightening, horrible, or upsetting that IN THE PAST MONTH, you ...
    □ have nightmares about it or thought about it when you did not want to?
    □ tried hard not to think about it/went out of your way to avoid situations that remind you of it?
    □ were constantly on guard, watchful, or easily startled?

□ felt numb or detached from others, activities, or your surroundings?

21. Over the past two weeks, have you often been bothered by:
Little interest or pleasure in doing things? □ **Yes** □ **No**
Feeling down, depressed, or hopeless? □ **Yes** □ **No**
Have your concerns led you to think you might be better off dead?

Time	Frequency
□ In the past □ Within the past week	□ Never □ Occasionally □ Often

22. Have you had thoughts of hurting or even killing yourself?

Time	Frequency
□ In the past □ Within the past week	□ Never □ Occasionally □ Often

Current psychosocial stressors:

23. What are some stressful things in your life? ____
____
____

24. In addition to those you have listed above, Please check other life events that are stressful for you:

□ Loss issues: death, job, etc.
□ Relational conflicts, toxic, violence
□ Occupational problems
□ Marital
□ Divorce/ separation/ break-up
□ Substance abuse
□ Health/ pain
□ Children: conflicts, family developmental cycle
□ Abuse or trauma history
□ Sexual dysfunction/ addiction
□ Lifestyle change/ retirement
□ Legal problems
□ Financial pressures
□ School problems
□ Other
□ Other

Spiritual:

25. Do you consider your faith or spiritual life important to you? □ **Yes** □ **No**
26. Describe your spiritual background: □ Agnostic □ Atheist □ Skeptic □ Christian
□ Jewish □ Muslim □ Buddhist □ Other: _________________________
27. Are you currently involved in a spiritual community? □ **Yes** □ **No**
□ Attend weekly □ Involved in small group □ Attend monthly
□ Attend sporadically □ Only for special occasions
28. Would it be helpful for this therapist to contact your spiritual leader? □ **Yes** □ **No**
If yes, please provide name and phone number: ____________________________
29. Please list anyone else you think would be helpful for this therapist to contact.

Name Relationship Phone Number
____
____
____

Today's Date: ___________

Confidential Pretreatment Questionnaire

Medical:

30. Who is your primary care ____

Is it ok for us to contact him/her? □ **Yes** □ **No**

Phone #:______________________**Address:**____

31. Are you under the care of a psychiatrist? □ **Yes** □ **No** **if so who:**______________________________

Is it ok for us to contact him/her? □ **Yes** □ **No**

Phone #:______________________**Address:**____

32. Please list any other doctors from whom you are receiving care:______________________________

33. When was the last time you had a physical exam? ____

34. Do you have any current health problems? If so, please list: __________________________________

____

____

35.Please place a check by any problems or symptoms that you have experienced

Heart Problems		Liver Problems		Visual Problems		Sensory Distortion	
Weakness		Stroke		Problems with balance		Parkinson's Disease	
Blackouts		Cancer		Brain Tumor		Multiple Sclerosis	
Amnesia		Lung Problems		Seizures		Pneumonia	
Fatigue		Constant Hunger		Weight Change		High Blood Pressure	
Headaches		Food Cravings		Allergies		Impotence	
Bowel/Bladder		Bulimia		Kidney Problems		Changes in Sexual Drive	
Menstrual Irregularities		Anorexia		Nausea/Vomiting		Personality Change	
Injury/Concussion		Fatigue					
Memory Problems		Loss/Changes in Consciousness		Dizziness		Episodic Disorientation	
Hallucinations		Speech Problems		trouble concentrating, easily distracted		Physical Change	
Stiff Neck		Incoordination		Hard to make up your mind or make decisions		Forgetful or trouble remembering things	
trouble breathing		joint pain		chest pain or pressure		Taking more risks such as driving faster	
back pain		stomach pain		frequent indigestion/ heartburn		problems sleeping/or still feeling tired after sleeping	
Other:		Other:		Other:		Other:	

36. Do you have any concerns about your appetite, weight loss or gain, or eating patterns? □ **Yes** □ **No**

If so, in the past 6 months has your appetite been: □ Normal □ Poor □ Excessive

In the past 6 months have you had any weight loss or gain? □ **Yes** □ **No** **How much?**_________

37. Do you worry about your body weight, shape, or food eaten? □ **Yes** □ **No**

38. In the past six months, how much sleep do you typically get each night? _______________________

39. Do you have: □ trouble falling asleep □ staying asleep □ waking up early □ no trouble with sleep

Today's Date: ___________

Confidential Pretreatment Questionnaire

40. Have you experienced any hallucinations such as:□ Seeing things □Hearing things □ Smelling things
If so, how often? ________________________________

Substance Use:

41. Please check any substances that you have abused
□ Tobacco □ Cannabis □ Cocaine □ Narcotics □ Prescription pills □ Caffeine
□ Alcohol □ Other

42. Describe your alcohol use:
□ never □ No Longer Use □ Monthly or less □ 2 to 4 times a month □ 2 to 3 times/wk
□ 4 or more times a week □ 5-6 times a week □ Daily.

- How much do you generally drink each time you drink? __________________________________
- Do you drink to the point of being drunk? □ Always □ Sometimes □ Never
- How many times have you been drunk in the past year?___________
- At what Age did you first start drinking? _____________
- When did you last have a drink? ____________________

43. Describe your tobacco use:
□ Never Use □ No Longer Use □ 1-2 times per week
□ 3-4 times per week □ 5-6 times per week □ daily

- What type of tobacco do you use: _______________________
- How much? __________________________________
- At what age did you first start using tobacco? ______

44. Describe your caffeine use:
□ Never Use □ No Longer Use □ 1-2 times per week
□ 3-4 times per week □ 5-6 times per week □ daily

- Type of use: _______________________
- How much? __________________________________
- At what age did you first start using caffeine? ______

45. Do you use drugs/chemicals recreationally (including prescription drugs and inhalants)?
□ Never Use □ No Longer Use □ 1-2 times per week
□ 3-4 times per week □ 5-6 times per week □ daily

- What type(s): ______________________________
- How much? __________________________________
- At what age did you first start using? _______________

46. Medications: (Current and recent Past) □ None * If necessary please use back of this page

Medication	Dose/Freq	Purpose	Start/Stop Dates	Response	Prescriber

Today's Date: ___________

Confidential Pretreatment Questionnaire

47. Is there anything else you think would be helpful for me to know?