PARSONS COUNSELING & PLAY THERAPY CENTER

ADULT YEARLY RENEWAL PACKET

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT

Welcome *to Parsons Counseling, LLC (PC, LLC.).*

This document contains important information about our services and business policies.

Client Name: _____ **Date:** _____

Social Security #: _____ **Birthdate:** _____

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I hereby authorize staff of Parsons Counseling, LLC. to render treatment and/or service to the client listed above. I understand that information or opinions will be given to others only with my written consent.

Relationship: ☐ self, ☐ child, ☐ other (specify).

_____

Signature of Client or Legal Guardian **Print Name** **Date**

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law including, specifically:

1. You consent in writing by signing a release of information, or
2. The disclosure is allowed by a court order and/or issued by a judge, or
3. The disclosure is made to medical personnel in a medical emergency, or
4. If you pose a threat of harm to yourself or an identified person, or
5. If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect.

State Law and Regulation do not protect any information about suspected child abuse or neglect, including spouse abuse. Kentucky law requires that child abuse and neglect be reported. In Kentucky, no one under the age of 16 can legally consent to sexual contact.

Initial here: _____

INTERNS: PC, LLC is working with qualified students to train them for the human services profession. They will maintain client confidentiality and maintain professionalism in the workplace. Interns will schedule appointments, work with clients, assist with intakes, and other office tasks.

Initial here: _____

APPOINTMENTS & TERMINATION: All office appointments are scheduled for 53 minute sessions. Consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time. If you are unable to keep a scheduled appointment, you must notify PC, LLC. **at least 24 hours in advance** to avoid the canceled or missed appointment fee of $30.00. To cancel an appointment, you may choose to leave a message on voicemail, leave a text message at 859-428-7862, or email at appt@parsonscounseling.com. ***Your compliance in keeping appointments and active participation in treatment is vital.***

- If you have not had an appointment for at least 60 days a letter will be sent to the address on file inviting you to schedule an appointment within 10 days before terminating your chart. ***If you choose to schedule an appointment and do not show your chart will be terminated.***
- **If you cancel or miss three visits within a 90 day period PC, LLC. reserves the right to terminate your chart immediately & refer you elsewhere.**

Initial here: _____

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

Appeals and Grievances: If you have a complaint about quality of care please contact the Practice Administrator by email at info@parsonscounseling.com within 30 days of the incident.

Initial here: _____

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a ***cash basis*** are expected to ***pay in full at time of service*** unless other arrangements have been made.
- ***Additional fees*** of $100 an hour will be charged for lengthy telephone communications, court attendance, and report/letter writing. Insurance does not cover this.
- If your case requires us to hire an attorney to assist or protect our office involving your case you will be responsible for ***all attorneys' fees***
- There is a ***$30.00 service fee*** **for checks returned** for Insufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay ***in cash*** the service charge ***PLUS*** the value of the check.
- I authorize my insurance to be billed for counseling services in attempt to assist in paying for my services.
- At any time during treatment ***should the client become ineligible for insurance coverage****, the client and/or responsible party agrees to notify the counselor and* ***will be responsible for 100% of the bill.***

Initial here: _____

CONSENT TO TREATMENT AND FEE:

By signing this contract, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, **you are responsible for payment** even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign Parsons Counseling, LLC. and all insurance benefits due to me to the full extent of my financial obligation to Parsons Counseling, LLC. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Kentucky State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

Initial here: _____

HIPPA Notice of Privacy Practices

Please mark one of the following: _____ I have received a copy of the HIPAA Notice of Privacy Practice (available at the Center or on www.parsonscounseling.com)

_____ I decline to receive a copy of the HIPAA Notice of Privacy Practice

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them; I have been given an opportunity to discuss these policies with a Parsons Counseling, LLC staff person and all questions I raised were answered to my satisfaction.

_____ _____ _____

Signature of Client/Legal Representative **Print Name** **Date**

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**

PARSONS COUNSELING & PLAY THERAPY CENTER

ADULT'S CONTACT INFORMATION

*Client Name: _____ *Date: _____

*Social Security #: _____ *Birthdate: _____ * Height: _____ *Weight: _____

*Gender at Birth: M or F (If applicable) Gender Identity: _____ Sexual Orientation: _____

*Address:_____

*City, State,Zip:_____

*Home Phone _____ *May we leave a message at home? Yes No

*Cell Phone _____ *May we leave a message or text the cell? Yes No

*Work Phone _____ *May we leave a message at work? Yes No

*Email _____ *May we email you or put you on our mailing list? Yes No

INSURANCE INFORMATION

****If you have Medicaid & other insurance in addition to Medicaid please list the OTHER insurance as the Primary Health Insurance. Medicaid will NOT pay if we do not bill the other insurance first. Ms. Lisa Parsons, Ms. Brittany Wills & Ms Jeanne Nakazawa are currently the only participating therapists with other private insurances outside of Medicaid. If you have other insurance & see another therapist you will be responsible for the full intake fee of $80.00. ****** For Medicaid, the client is the subscriber; all other insurances an adult parent is the subscriber.

*Primary Health Insurance: _____ *ID #: _____ *Group #: _____

*Subscriber Name: _____*Client's Relationship to Subscriber:_____ *Subscriber DOB: _____

*Subscriber Address: _____

Secondary Health Insurance: _____ ID #: _____ Group #: _____

Subscriber Name: _____Client's Relationship to Subscriber:_____ Subscriber DOB:_____

Subscriber Address: _____

***CURRENT PRESENTING PROBLEM(S) or CHANGES:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please check all that apply:

	Abortion		Gender identity		Overweight
	Abuse - emotional		Goals not being met		Panic or anxiety attacks
	Abuse - neglect		Grieving, mourning		Parenting
	Abuse - sexual		Guilt		Perfectionism
	Adoption		Headaches, pains		Pessimism
	Aggression		Health, illness		Phobias
	Alcohol Use		Hearing voices		Physical problems
	Ambition		Helplessness/hopeless		PMS
	Anger		Hostility		Poor self-care
	Anxiety		Hyperactivity		Pornography use
	Arguing		Impulsive spending		Procrastination
	Attention problems		Impulsiveness		Relationship problems
	Career concerns		Incest		Relaxation
	Childhood issues		Indecision		Re-marriage
	Children – care of		Inferiority feelings		Risk-taking
	Children - custody		Infertility		Sadness
	Children - management		Inhibitions		School problems
	Choices I've made		Interpersonal conflicts		Self-abuse - burning
	Chronic pain		Irresponsibility		Self-abuse - cutting
	Codependence		Irritability		Self-abuse - other
	Communication		Judgment problems		Self-abuse - scratching
	Compulsive spending		Laziness		Self-abuse – pulling hair out
	Confusion		Legal matters, charges, suits		Self-centeredness
	Constant conflicts		Loneliness		Self-control
	Crying		Loss of control		Self-esteem
	Deaths		Losses		Self-neglect, poor self-care
	Debt		Loss of interest in activities		Separation
	Decision making		Loss of interest in sex		Sexual addiction
	Dependence		Low energy		Sexual conflicts
	Depression		Low frustration tolerance		Sexual desire differences
	Distractibility		Low income		Shyness
	Divorce, separation		Low mood		Smoking
	Domestic violence		Marital conflict		Spirituality
	Drug abuse – over the counter		Marital distance		Step-parenting
	Drug abuse - prescription		Marital infidelity/affairs		Stress
	Drug abuse – street drugs		Medical concerns		Stress-management
	Drug abuse - alcohol		Memory problems		Suspiciousness
	Education		Menopause		Temper problems
	Employment – lack of		Menstrual problems		Tension / stress
	Employment - overdoing		Mixed feelings		Thought disorganization
	Employment problems		Mood swings		Threats of violence
	Employment - termination		Motivation		Tiredness
	Emptiness		Mourning		Tobacco use
	Exhaustion		Nail-biting		Unhappiness
	Failure		Nervousness		Violence
	Fatigue, low energy		Nightmares		Violence – victim of crime
	Fears, phobia		Obsessions, compulsions		Weight and diet issues
	Financial troubles		Outbursts		Withdrawal - isolating
	Friendship problems		Oversensitive to criticism		Work problems
	Gambling		Oversensitive to rejection		Worry all the time

Initials of Parsons Counseling, LLC Representative: _____ Date: _____

PARSONS COUNSELING & PLAY THERAPY CENTER

MEDICATION RECONCILIATION RECORD for ALL MEDICATIONS

Client Name: _____ **Birthdate:** _____

Date: _____

❑ **No Known Allergies OR List Allergies:**

Current Medications: *Prescribed medications, herbal supplements, vitamins, over-the-counter drugs, everything that you are taking on a regular basis for any reason.*

Medication Name	Dose and Frequency	Date Started	Date Discontinued	Reason for Taking It	Prescriber (first and last name with specialty)

Initials of Parsons Counseling, LLC. Representative: _____

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Adult

Client Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Parsons Counseling, LLC. to use or disclose protected health information from the mental health records of the client listed above, which may include psychiatric diagnosis, treatment plans, and progress (written, verbally or electronically) to the following and initial for my consent:

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Inform physician of therapeutic services and any medical or mental concerns.

***Psychiatrist or Prescribing Doctor of Psychotropic Drugs (if applicable):**

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate and obtain medical information from the physician to assist in meeting any medical, medication, or mental concerns.

Emergency Contact:

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: In case of a medical emergency and scheduling appointments.

Support person involved in treatment (if desired):

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Appointments, progress of treatment goals, concerns, and areas where support person can make improvement to assist client.

DCBS or Agency who has custody of child:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate with DCBS/agency to report progresS & therapeutic goals regarding behavioral or mental health concern to assist in reaching DCBS or agency goals & obtain a copy of most recent Family Prevention Plans/case plans.

PARSONS COUNSELING & PLAY THERAPY CENTER

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Adult

Legal or other:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: _____

By signing below, I acknowledge that I have read and understand this Authorization

1. I understand that, unless withdrawn, this authorization will expire in one year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Parsons Counseling, LLC. at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that Parsons Counseling, LLC will NOT give copies of client notes without another release signed indicating such.
5. I understand that I may inspect or copy my mental health records.
6. I understand that I may refuse to sign this authorization and that Parsons Counseling, LLC. will not allow my refusal to interfere with receipt of payment for mental health and counseling services.
7. I understand that I am entitled to receive a copy of this authorization.

_____ _____ _____

Signature of Client/Legal Guardian/Authorized Person **Relationship to Client** **Date**

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**