Client Intake Form

Client Information: **Date:___ /____/____**

Name:____

Address:____
City/State/Zip:__________________________________
Cell Phone:_____________________________________
Birth Date:______________________________
Email:___________________________________
Cultural: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian
☐ Bi-racial ☐ Other: ____________________

Financial: ☐ Not Working ☐ 0-$25,000 ☐ $25,001 – 49,999 ☐ $50,000 - $69,999
☐ $70,000 +

Other Parent Information (if client is a minor and parents are separated/divorced

Parent Name:_____________________________
Address:________________________________ City/State/Zip:______________________
Email:__________________________________

Other Parent Information

Parent Name:___________________________
Address:______________________________ City/State/Zip:______________________
Email:________________________________

Primary Insurance Information:

Insurance Company:_______________________ Insured's Employer:___________________
Work Phone:_____________________________ Plan Name:__________________________
Insured's ID NO:__________________________ Policy/Group:________________________
Responsible Party: (**Circle One**) Self Parent Spouse Guardian
Guarantor for Client:______________________ Guarantor's SSN:_____________________
Guarantor's DOB:_________________________ Guarantor's Cell:____________________
Guarantor's Address:____

Parent Initial: ______
Staff Initial: ______

Empowering Parents

Secondary Insurance Information:

Insurance Company:_____________________ _________ Insured's Employer:___________________________
Plan Name:_______________________________________ Insured's ID:_________________________________
Insured's Group:___________________________________

Authorization to Release Information and to Pay Benefits Directly to Provider:

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of benefits to be paid directly to the therapist for services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

I understand that I am responsible to pay applicable co-payments and co-insurance amounts. Co-payments are due the day services are rendered. Service will be declined for nonpayment.

Empowering Parents/Turning Leaf Counseling and Consultation, LLC will make every effort to inform you of the cost associated with services. However, there are many factors that are beyond our knowledge or control such as your deductible, co-insurance, out of network costs, etc. Therefore, there may be additional costs above and beyond your copayment. You are advised to contact your insurance company to educate yourself on total cost of receiving services.

I understand that Empowering Parents KC/Turning Leaf Counseling and Rizk Assessment and Psychological Services is using a third party biller **"Anchor Point Billing Solutions"**. Anchor Point Billing Solutions will be verifying insurance benefits as well as filing for payment. Anchor Point Billing Solutions may be sending monthly statements on behalf of EPKC/Turning Leaf Counseling and Rizk Assessment and Psychological Services.

I understand it is my responsibility to inform Empowering Parents KC/Turning Leaf Counseling and Consultation LLC/Rizk Assessment and Psychological Services if my coverage or insurance changes. I am responsible for paying for the services if insurance denies payment or if insurance has termed.

Should there be two parents who are divorced and jointly pay for counseling the respective parent who brings the child must pay the full fee and be reimbursed by the other party. If joint custody, both parents must agree to the therapy. Therapy will not be conducted without payment made at the time of service.

Initial: _______ - I initial to infer that I am in agreement with said information listed above.

Financial Policy

Providers are committed to providing you with the best possible service. Your clear understanding if our Financial Policy is important to our professional relationship. Please ask if you have any questions about fees, the Financial Policy, or your responsibility for payment.
All clients must complete the information form and financial policy prior to seeing the therapist. Your insurance provider may have additional forms that they require or request.

Parent Initial: ______
Staff Initial: ______

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PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, payable to **Empowering Parents KC/Turning Leaf Counseling/Rizk Assessment and Psychological Services** or credit card/health savings account card for payment. If credit card is used a 1.5% fee will be incurred.

Cancellations

A 24 hour notice is required for all cancellations. A fee of **$100** will be charged for the missed appointment. Insurance companies and your employee assistance programs do not pay for missed appointments. Your appointment time is reserved specifically for you. Policies regarding charging for missed appointments appear herein. Please help us serve you better by keeping your scheduled appointment. Let us know of any questions or concerns. The fee of **$100** will be charged to the credit card on file for guarantee of payment plus 1.5% credit card fee.

More than two No Show's could result in EPKC or Turning Leaf Counseling discharging you from services.

Insufficient Funds

I agree to pay any and all bank fees charged in the event of checks received with insufficient funds. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account and for professional services and/or consultation rendered. I have read all of the information herein, and have also completed the "Client information" form. I certify that the information provided is true and correct to the best of my knowledge; and agree to notify my provider of any changes regarding the above information or other change that may impact my treatment. Charges for NSF will be $50.00 plus return charges…likely $25.00 - $35.00for bank fees.

Consultation

During your divorce or modification, there may be occurrences when the therapist is asked to meet with, contact or write reports or emails to the attorneys involved, specifically the guardian ad litem for the child(ren). There may be consultation fees associated with your particular case. These fees may apply to the case. Consultation with attorneys or other therapists, co-parent counselors, take us away from our practice and making time for other clients. Often, we are working late nights, and weekends to meet the needs of the clients. The fee for depositions, reports, court testimony, email review/responses, phone calls, etc. As a result, there will be a minimum of four hours charged for court or depositions. Fees for such services are paid in advance or deposited with your attorney in advance of the required date. **Court fees are nonrefundable. I understand that I may be asked to place $500 dollars in an escrow account to absolve any outlier costs associated with my case.**

Initial:__________

Turning Leaf Counseling Professional Fees

Rizk Assessment and Psychological Services

Empowering Parents KC Professional Fees

Parent Initial: ______
Staff Initial: ______

Empowering Parents

Service	Fee
***Initial Intake**	**$150.00**
***Individual Psychotherapy**	**$125.00**
***Psychological Assessments**	**$2000.00**
***Custody Evals and Home Studies**	**$ 150.00/hr**
***No Show/Late Cancellation**	**$ 100.00**
***Attendance at Meetings (including travel)**	**$150.00/hour**
***Court/Depositions (4 hour minimum/nonrefundable)**	**$200.00/hour**
*** Court Prep**	**$200.00**
***After Hour Calls**	**$100.00/call**
***Hardship Waivers**	**$500.00**
***Review of emails, responses to emails, reports)**	**$100.00/hour**
FMLA/Homebound Letters	**$ 50.00**
Disability Paperwork	**$ 50.00**

***<u>Empowering Parents fees are sliding fee scale</u>**

Empowering Parents will provide letters, forms, and reports, which must be paid in advance. Court testimony is paid in advance with a 4-hour minimum based on current sliding fee scale plus mileage, which is nonrefundable. Any other service is based on the hourly sliding fee scale rate. This applies to Empowering Parents only. Professional fees for Turning Leaf and Rizk Assessment and Psychological Services are listed above.

Initial: _________

Custody Services

Please note that if you have divorce or custody papers that require both parents to make joint decisions for medical and/or mental health issues then both parents must agree to the treatment of a minor child. Both parents must sign all consents in these circumstances. Failure to notify Turning Leaf Counseling/EPKC will result in immediate discharge from services. Both parties must provide the most up-to-date parenting plan prior to starting services.

Client Rights and Responsibilities

I have read the client rights and responsibilities – copy with the receptionist or attendant.

Security of Records

Security of Records: Your treatment and related financial records are kept in a locked file cabinet. Records will not be made available to others without a signed authorization to release the information except where allowed or mandated by law. There is a charge for copies of records, which is in accordance with Missouri State Law who regulates these fees. We follow HIPAA Laws and will abide by HIPAA to ensure the safety and security of our clients. You may request access to your records and you understand that it will take 30 days to receive receipt of records if approved by therapist and management team. If not approved you understand you will receive notification of why by mail. Records will not be disbursed via email and only provided by client picking up records from the office.

Initial:_______

Security Cameras/Recordings

Parent Initial: ______
Staff Initial: ______

I agree that no camera or audio recording will be allowed in therapy sessions.

Retention of Records

- Treatment and financial records are retained for a period of 7 years following the termination of treatment for adults and until age 28 in the case of minors.
- If you have been involved in co-parenting records will not be shared without both parties agreeing.
- Special rules relating to release of treatment records containing information regarding drug and alcohol abuse include: CFR 42, Part 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is prohibited.
- If this is your desire please notify therapist upon intake or anytime during treatment. All records are destroyed in a manner that ensures complete confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

Discharging Clients

Your file may be closed for no-showing for appointments, no contact, nonpayment of fees, lack of progress, dishonesty or treatment interfering behaviors. Therapist will make every effort to contact you either by phone or by mail to re-engage you or your child in services. If there is a lack of progress it will be discussed with you, and therapist can assist you with a referral to another provider.

After Hour Emergencies

Turning Leaf Counseling and Consultation, LLC and EPKC and Rizk Assessment and Psychological Services is unable to provide 24/7 emergency coverage. You are welcome to attempt to call, and if therapist is available emergency services will be provided. If it is a life-threatening emergency, you will need to call 911 immediately. If it is urgent and you are unable to reach your therapist, please call the Access Crisis Intervention line (open 24 hours) at 1-888-279-8188. Business hours do vary, but typically are Monday through Friday 8am-5pm. No emergency services are provided after 5pm.

Authorization to Treat

I give consent to my therapist to provide assessment and therapeutic services to my child, within the scope of their license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem as efficiently as possible. I agree to cooperate with my therapist in this treatment process and to follow through with any medical treatment, as prescribed by the treating physician.

Confidentiality of Cell phones and Email

If you choose to email your therapist from your personal email account, please limit the contents to basic issues such as scheduling and cancellations. We will not respond to personal or clinical concerns via regular email or phone text messaging.

Interns

I understand that my case may be assigned an intern. The intern is a Masters Level student from the University of Kansas. They are working on their Masters in Social Work and focusing on their clinical expertise. The intern is under the supervision from a Licensed Clinical Social Worker. I understand that the Intern does not work alone and will be under the supervision of an LCSW. I also understand that an intern will provide practice under the same guidelines as a licensed therapist within the organization. Please notify administration if you DO NOT want an intern involved in your case. Please understand that if you OPT out of having an intern involved this may delay

Parent Initial: ______
Staff Initial: ______

your services in getting in to see a fully licensed therapist. I also understand that an intern may be sitting in my session with my therapist. This is so that they are provided hands on learning.

Initial:______

Empowering Parents KC

Rizk Assessment and Psychological Assessments

Turning Leaf Counseling

Confidential

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name____ Date of Birth_______________

I ____, hereafter designated as the client, request and consent to those services and treatment offered by Turning Leaf Counseling (TLC)/Empowering Parents KC (EPKC)/Rizk Assessment and Psychological Assessments (RAPS), which may include therapy/counseling, consultation and assessment.

I understand that as a client of EPKC/TLC/RAPS, I may be eligible to receive a services including but not limited to outpatient individual and family psychotherapy, couples therapy, group therapy, psychological assessments, autism assessments, consultation and high conflict resolution services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. I understand that the goal of the initial assessment process is to determine the best course of treatment for me. Plans and recommendations for treatment will be discussed with me and I will participate in the planning thereof. Typically treatment is provided over the course of several weeks or months. Medication services may be recommended and a referral provided.

I understand that all information that I disclose to my mental health service provider is confidential. During the course of treatment, it may be necessary for my mental health service provider to communicate with other providers. I may authorize any discussion with other providers, including but not limited to treating physicians, case managers, and other necessary individuals for the continuity of the mental health

Parent Initial: ______
Staff Initial: ______

treatment I may receive. I further understand that there are specific and limited exceptions to the types of information that may be disclosed which include the following:

A. When there is a risk of imminent danger to myself or another person, the clinician is legally and ethically bound to take necessary steps to prevent danger, such as informing law enforcement or others that are in danger.

B. When there is a suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.

C. When a valid subpoena and/or court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests; understand that my medical records will be released pursuant to such court order or subpoena.

I understand that a range of mental health professionals, some of whom are in training, may provide services. All professionals-in-training are supervised by licensed staff. If a professional-in-training is assigned to my case, I consent to receive services from that professional-in-training. You will be informed of such professional-in-training and will have the right to opt out.

I understand that while psychotherapy and/or medications may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects. I understand that my active participation and compliance with treatment will be an important factor to achieving a positive outcome from mental health treatment. I understand that TLC/EPKC/RAPS does not guarantee a positive outcome concerning the state of my mental health.

If I have any questions regarding this consent form or about the services offered by TLC/EPKC/RAPS, I should discuss them before signing this consent.

I have read, understood, and agree to abide by the provisions thereof. I have been given a copy of the **Notice of Privacy Practices, if requested**. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by EPKC/TLC/RAPS and I understand that I may stop treatment at any time. I understand and agree that I must inform EPKC/TLC/RAPS if I decide to stop treatment.

I authorize the release of any medical records or other information necessary to process insurance claims (including Medicaid claims). I also authorize payment of benefits directly to EPKC/TLC/RAPS for services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

____ ____________________

Signature of Client, Parent, or Legal Guardian **Date**

(If the client is under 18 years of age, this agreement must be signed by a parent of guardian of the person, or by the person having legal custody of said minor.)

Parent Initial: ______
Staff Initial: ______

Empowering Parents

I have read all of the information herein. I certify that the information provided is true and correct to the best of my knowledge; and agree to notify my provider of any changes regarding the above information or other change that may impact my treatment. I agree that I have thoroughly read pages 1-7, including Authorization to Release Benefits, Financial Policy, Cancellation Policy, Insufficient Funds, Consultation, Professional Fees, Custody Services, Rights and Responsibilities, Security of Records, Cameras/Recordings, Retention of Records, Discharges, Emergencies and After Hours, Authorization to Treat and Confidentiality with Cell phone and Emails.

Signature of Client/Parent/Guardian)___________________________________ Date:__________________

Signature of Therapist:____ Date:______________________

EPKC, TLC, and RAPS Credit Card Payment Authorization Form

By signing this form, you give permission to debit the amount for all services you have received, which may include deductible, copays, consultation, etc.
Cardholder Name:____
Cardholder Address:____ ZIP:
Account Number:____
Expiration Date:____
CCV (3 or 4 digits) ___________________________
Signature:_______________________________________ Date:_____________

I authorize the above-named business to charge the credit/debit card indicated on this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit/debit card company; so long as the transaction corresponds to the terms indicated in this form. I can at any time, discontinue these charges, but must do so in writing.

Empowering Parents

PROBLEM LIST

CLIENT NAME: ___________________________________ DATE: ________________

NAME OF PERSON COMPLETING FORM: _________________________________

CURRENT SYMPTOMS:

☐ANGER

☐ LOSS OF INTEREST IN WHAT I ENJOY

☐ DECREASED MOTIVATION

☐ EXCESSIVE WORRYING

☐ RACING THOUGHTS

☐ SLEEPING TOO MUCH

☐ WITHDRAW FROM OTHERS

☐ FIRE SETTING

☐ BEHAVIORAL ISSUES AT HOME OR SCHOOL

☐ SEXUAL PROBLEMS (medical)

☐ STEALING

☐ IMPULSIVITY

Parent Initial: ______
Staff Initial: ______

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☐ FAMILY CONFLICT/DOMESTIC VIOLENCE

☐ INATTENTION/POOR CONCENTRATION

☐ HYPERACTIVITY

☐ DIFFICULTY FALLING/STAYING ASLEEP

☐ IRRITABILITY

☐ LOW SELF-ESTEEM

☐ SADNESS

☐ RECENT SUICIDE ATTEMPT

☐ THOUGHTS OF HARMING SELF/OTHERS

☐ TIREDNESS

☐ HOPELESSNESS

☐ HELPLESSNESS

☐ CRYING SPELLS

☐ FLASHBACKS

☐ NIGHTMARES/TERRORS

☐ FEAR OR ANXIETY AROUND OTHERS

☐ AFRAID TO LEAVE HOME

☐ FEAR OF PLACES, CROWDS, ETC.

☐ SEPERATION ANXIETY

☐ DIFFICULTY MAKING OR KEEPING FRIENDS

☐ VICTIM OF CRIME

☐ HEARING SOUNDS OR VOICES OTHERS DON'T HEAR

☐ RECURRING UNWANTED THOUGHTS

☐ PARANOIA

☐ SEEING THINGS THAT OTHERS DON'T SEE

☐ CHRONIC PAIN

☐ HEADACHES

☐ NAUSEA

☐ HEART RACING OR PALPATATIONS

☐ SLOW HEART BEAT

☐ STOMACH ACHES

☐ EXCESSIVE SWEATING

☐ SIGNIFICANT MEDICAL CONCERNS

☐ EXCESSIVE STRESS/ANXIETY/PANIC

☐ INAPPROPRIATE SEXUALIZED BEHAVIOR

☐ SEXUAL CONTACT WITH SIBLINGS

☐ SEXUAL CONTACT WITH PEERS

☐ MOOD REGULATION ISSUES

☐ DRUG USAGE/ADDICTION ISSUES

☐ ALCOHOL USAGE/ADDICTION ISSUES

☐ GAMBLING ADDICTION (HARD TIME STOPPING)

☐ SEXUAL/PORN ADDICTION

☐ FEAR OR HARM OF DOMESTIC ANIMALS

☐ ATTACHMENT/BONDING ISSUES TO OTHERS

☐ SEPERATION FROM CAREGIVERS

☐ DIFFICULTY GETTING ALONG WITH OTHERS

☐ SELF SABATOGING BEHAVIORS

☐ HAS WITNESSED A TRAUMATIC EVENT

☐ HAS BEEN PHYSICALLY ABUSED

☐ HAS BEEN SEXUALLY ABUSED

☐ HAS BEEN IN A NEGLECTFUL SITUATION

☐ CUTTING BEHAVIOR-PAST OR PRESENT

☐ EMPLOYMENT/EMPLOYER ISSUES

☐ OTHERS ARE OUT TO GET ME

☐ WEIGHT GAIN

☐ WEIGHT LOSS

☐ CONCERNS ABOUT WEIGHT

☐ SHORTNESS OF BREATH

☐ CONCERNS ABOUT APPEARANCE

☐ FREQUENT DIETING

☐ ANOREXIA/BULEMIA ISSUES

☐ COMPLIANCE ISSUES WITH MEDICATION

Parent Initial: ______
Staff Initial: ______

Empowering Parents

PLEASE LIST ANY PROBLEMS THAT YOU WANT THERAPIST TO BE AWARE OF:

____

Parent Initial: ______

Staff Initial: ______