Kingsport Counseling Associates, PLLC
Individual, Marriage and Family Counselors

CLIENT INFORMATION

Date _____

Full Name _____ Age _____ Gender _____

Preferred Name _____ E-mail _____

Address _____City_____ State_____ Zip_____

Phone _____

Social Security Number _____ Date of Birth _____

Married ☐ Single ☐ Widowed☐ Divorced ☐ Separated ☐

Spouse (Partner) _____ Age _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone _____

Education: Elementary/ Jr. High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post Graduate ☐

Children (give ages) _____

_____

Medical Conditions _____

Medications _____

Physician _____ Address_____

Phone _____

Have you ever had counseling or therapy before? Yes☐ No ☐ If yes, please give dates and with whom _____

_____

May we contact former counselor/ therapist? Yes ☐ No ☐

Are you currently under psychiatric care? Yes ☐ No ☐ If yes, Psychiatrist Name _____

Address _____ Phone _____

Are you currently taking any psychotropic medications? Yes ☐ No ☐ If yes, please list _____

_____

Who referred you? ☐ Insurance/EAP ☐ Internet Search ☐ Physician ☐ Phone Book ☐ Friend ☐ Other _____

What problems are you having that caused you seek counseling/therapy or be referred?_____

_____

_____

_____

_____

Have you ever attempted suicide or had serious suicidal thoughts? Yes ☐ No ☐ If yes, are you having suicidal thoughts now? Yes ☐ No ☐

Have you ever been hospitalized for a mental condition? Yes ☐ No ☐ If yes, when did this occur and where? _____

_____

Emergency Contact _____ Phone _____

Address _____

To the best of my knowledge, the information given above is true and correct.

Signed _____ Date _____

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Statement of Informed Consent for Group Therapy

I (client name)_____ agree and give consent for group therapy and treatment by _____(Therapist). I understand that there are certain risks involved, such as being willing to disclose personal information and to be open and honest with the therapist and other members of the group. I understand that I have entered into this therapeutic relationship voluntarily and may terminate treatment at any time, however there might be risks involved in terminating treatment early.

It is encouraged that each participant in group therapy maintains a ‘‘no secrets’’ policy and that issues be addressed openly and honestly during the sessions. I understand that by entering into group therapy, each member of the group accepts an investment into the therapeutic process and that working toward change may involve experiencing intense and sometimes painful emotions. I understand that working toward change in therapy can have both negative and positive effects on the individual.

The scope and nature of this treatment has been explained to me and I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the therapist and/or his staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

Confidentiality
I understand that confidentiality will be maintained at all times by the Therapist within legal requirements of the State of Tennessee and ethical guidelines according to the American Association of Marital and Family Therapists Code of Ethics. I understand that confidentiality will not be maintained if any person threatens or gives reason to believe that they will harm themselves or others. *I understand that other members of the group have agreed to maintain confidentiality, but the Therapist CAN NOT guarantee that this confidentiality will be maintained other members of the group _____ (Initials)*

Privacy of Information (HIPAA)
I acknowledge that we have been given a copy of the therapists *Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights* which describes how records and information about my treatment will be handled.

Credentials and Supervision
The Therapist is Licensed by the State of Tennessee as a Therapist or is in the process of becoming licensed. I understand that the therapist will, on occasion, participate in clinical supervision with other counseling professionals. Cases will be discussed with other counseling professionals solely for the purpose of gaining additional perspective, input and treatment direction. Confidentiality will be maintained in this supervision and the names of clients will not be used. The credentials of the therapist have been explained to me.

Fees
I understand the fees involved in this treatment and that payment is expected at the time of the session(s), unless other arrangements have been made. I also understand that failure to pay the expected fees could terminate treatment and the settlement of any unpaid fees will be turned over to a collection agency. _____(Initials)

Sessions
The length of sessions are normally around 90 minutes. I understand that group therapy is dependent upon ALL members of the group participating. By entering into the group process I agree to participate in all group sessions. I agree to arrive on time for scheduled group sessions. ***“No shows” for group sessions are subject to charged for the session.*** **Cancellations need to be made 24 hours prior to scheduled sessions, except in the case of personal or family emergencies. Cancellations not made within 24 hours are also subject to being charged for the session (except in emergencies). If a client misses more than two consecutive sessions, the client will be considered withdrawn from the group.** _____**(Initials)**

By signing below, we have read, understand and agree to the Statement of Informed Consent for Group Therapy:

Client _____ Date _____

Therapist _____ Date _____

Fee Payment Agreement and Medical Billing Release

I understand the fees involved in this treatment and that payment is expected at the time of the session(s), unless other arrangements have been made. I also understand that failure to pay the expected fee could terminate treatment**.** The basic session fee is $120.00 for a 50 minute session *(insurance discounts and/or sliding scale fees may apply for this fee)* **"No shows" and late cancellations for appointments will be charged for the session. Cancellations need to be made 24 hours prior to scheduled appointments.** _____*(initials)*

We offer several payment options for therapy and counseling sessions. Payment for services is expected at the time of the session unless other arrangements with the therapist have been made (e.g. insurance or third party payments). Session payments are due at the time of the session. We are able to accept Cash, Checks, Money Orders as well as Visa, Mastercard, Discover Card and American Express.

Payments
Check or Money Orders to: Kingsport Counseling Associates, PLLC, 1417 Warpath Dr., Suite B, Kingsport, TN 37664.
Credit cards are accepted. Pre-payments may be made online by credit card prior to the session at the website: *www.kingsportcounseling.com.*

Insurance
Coverage for therapy varies according to a person's plan and the insurance company. We will gladly file insurance claims with the understanding that if the insurance plan does not cover therapy, the client would need to use other payment options. Any co-payments are due at the time of the session.

In cases where the client has limited income and does not have health insurance or an EAP available, fees will be charged on a sliding scale based on family income. If this is the case, a copy of the sliding scale schedule will be provided.
Please check the payment option you plan to use:

☐ Check or Cash payment at time of session

☐ Credit card payment

☐ Insurance or EAP (please bring copy of insurance card/ info to session)

Insurance Company_____
Policy Number _____ Group Number _____
Co-pay _____ Primary Insured _____
Primary Insured Date of Birth_____
Employer of Primary Insured _____
Insurance Company Phone _____

*By signing below, I acknowledge I have read, agree to and understand the fee payment policy above. I also authorize the therapist to release necessary medical information to third parties for billing purposes and payment of medical benefits to the therapist (Kingsport Counseling Associates, PLLC NPI#1356766133). *(*Lines 12 and 13 on universal insurance claim form CMS-1500)*

Signature_____ Date_____
Client Name(Print) _____
Therapist Signature_____
(Updated 3-4-2014)

Health Insurance Portability and Accountability Act (HIPAA)
Patient Notification of Privacy Rights

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Preamble

The Licensing Laws of the State of Tennessee provide privileged communication protections for conversations between your therapist and you in the context of your established professional relationship with your therapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers, and in some cases, not to the patient himself/herself. HIPAA provides privacy protections regarding your personal health information, which is called "protected health information," which could personally identify you. PHI consists of three (3) components: *treatment, payment, and health care operations.*

Treatment refers to activities in which Kingsport Counseling Associates, PLLC (KCA) provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when KCA obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided to you.

Health care operations are activities related to the performance of KCA practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "medically necessary."

The *use* of your protected health information refers to activities of office conducts in filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. *Disclosures* refers to activities you authorize which occur *outside* my office, such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

Uses and Disclosures of Protected Health Information (PHI) Requiring Authorization

The State of Tennessee requires authorization and consent for treatment, payment and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. We may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you).

Additionally, if you ever want us to send any of your protected health information of any sort to anyone outside our office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement that you sign an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that we speak with your physician about your treatment and/or medications. Before I talk to that physician, you will first have signed the proper authorization for us to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: our psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-patient in treatment settings, HIPAA permits keeping 'psychotherapy notes' separate from the overall 'designated medical record." 'Psychotherapy notes' cannot be secured by insurance companies, nor can they insist upon their release for payment of services. "Psychotherapy notes' are *our* notes and are defined as follows: " notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes' are not the same as your "progress notes' which provide the following information about your care each time you have an appointment at our office: assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If we are forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time we will be able to limit reviews of your PHI to only your "designated record set" which includes the following: all identifying paperwork you completed at your initial visit, all billing and reimbursement information, a summary of our first appointment, your mental status and progress notes for each session, your treatment plan, discharge summary, reviews by managed care companies, results of psychological testing, and any authorizations you have signed. Please note that the actual test questions or raw data of psychological tests are *not* part of your 'designated mental health record set.

You may, in writing, revoke all authorizations to disclose PHI at any time. You cannot revoke an authorization to disclose PHI that has already been disclosed, or an authorization that was obtained as a condition for obtaining insurance in cases where Tennessee law provides the insurer the right to contest the claim under the policy.

Business Associates Disclosures
HIPAA requires that we train and monitor the conduct of those performing ancillary administrative services for my practice and refers to these people as "Business Associates." These include our secretaries, telephone answering service, health insurance billing service and collection agency. These business associates need to receive some of your PHI in order to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information in accordance with state and federal standards.

Uses and Disclosures Not Requiring Consent nor Authorizations
By law, PHI may be released without your consent or authorization in the following instances:

1. Child abuse
2. Suspected sexual abuse of a child
3. Adult and domestic Abuse
4. Health oversight activities (i.e. licensing boards investigations)
5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

No information will ever be released for any sort of marketing purposes.

Patient's Rights and My Duties
You have a right to the following:

The right to request restrictions on certain uses and disclosures of your PHI. we may or may not agree to these restrictions, but if we do, they shall apply unless our agreement is changed in writing. *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so we will send them to another location of your choosing. *The right to inspect and receive a copy* of your PHI in the designated mental health record set foras long as PHI is maintained in the record. *The right to amend* material in your PHI, although we may deny an improper request and/or respond to any amendment(s) you make to your record of care.

The right to an accounting of non-authorized disclosures of your PHI.

The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of same. *The right to revoke any authorization* of your PHI except to the extent that action has already been taken.
For more information on how to exercise each of the rights, please do not hesitate to ask me for further assistance. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. We reserve the right to change our privacy policies and practices as needed. Current practices are applicable unless you receive a revision of our policies at a future time. Our duties as a therapists include maintaining the privacy of your PHI, providing you with this notice of your rights and our privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

Complaints
The appointed "Privacy Officer" for Kingsport Counseling Associates, PLLC per HIPAA regulations is listed below. If you have any concerns that your privacy rights have been compromised, please let us know immediately. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date – March 4, 2014

L. Gordon Brewer, Jr. M.Ed., LMFT
1417 Warpath Dr., Suite B
Kingsport, TN 37664
Phone: 423-408-2601
Email: kptcounseling@gmail.com
Website: kingsportcounseling.com