

Hello.

It is with great pleasure that I welcome you to our clinical practice. Our hope is to serve you and/or your family to work toward the best possible outcome.

You have several rights as a client. These include the right to know fees, ask questions and to end services at any time. The paper work which follows will also inform you of the limits of confidentiality and how your personal health information may be used with insurance companies.

The following paperwork must be completed in its entirety for the assessment and following counseling sessions to take place. Your information is confidential within the limits described on the following pages. Keeping your privacy is something we take very seriously. If you need assistance completing some of the questions, we will gladly assist you at our first session.

Please have a seat in the waiting area. Although we are expecting you, we may be with another client and will be with you as soon as possible.

Again, thank you kindly for choosing our practice. We look forward to providing counseling services to help you.

Sincerely,

Janet Vessels, M.S. LPCC RPT-S

Professional Biography

I received my master's degree from Kansas State University in Human Development and Family Studies, with a specialization in adolescence and youth. I am licensed as a professional clinical counselor (LPCC) in the Commonwealth of Kentucky and a registered play therapist (RPT) through the Association for Play Therapy . I have over fourteen years of experience in mental health counseling with individuals, families and groups. I am trained in a variety of counseling methods including play and sandtray therapy, dialectical behavioral therapy, Theraplay, cognitive behavioral therapy, and Eye Movement Desensitization and Reprocessing (EMDR).

I have served as an adjunct faculty member in the Behavioral Science Department of Bluegrass Community and Technical College. I have taught family studies courses (child development and human sexuality) as well as personality theories, general psychology and human relations.

I have conducted more than 1000 training workshops in child social/ emotional development, adolescent and adult suicide assessment and intervention, play therapy, parenting, ethics, nature games to enhance self-esteem, play therapy, marriage enrichment, separation & grief, Army Family Team Building, workplace violence, stress management, mental health laws and various mental health assessments: Brief Psychiatric Rating Scale, Multnomah Community Ability Scale, and the Clinical Alcohol and Drug Scale.

I am a professional member of the Association for Play Therapy (APT), and American Counseling Association (ACA), the Eye Movement Desensitization and Reprocessing International Association (EMDRIA) and the International Society for the Study of Trauma and Dissociation (ISST-D). I am currently the secretary of the Kentucky chapter of the Association for Play Therapy.

I have been interviewed for article in Parents magazine, Generation X, and share my knowledge on local news broadcasts.

Clinical Approach

My approach to counseling is that every person has strengths, resources and resiliencies to overcome obstacles and life problems. Counseling will not be a long process if the client and I work together to develop skills to solve current and future problems. I will offer various strategies and goals that focus on education and guidance which are clear, logical and practical.

If you are interested in counseling, please read and complete the information in this packet.

1. Client and Intake information
2. Notice of Privacy Practices Handout is available

This Information is required before services are provided.

Client and Intake Information

Full Name _____ SS# _____ DOB _____

Address _____ City _____ Zip _____

Home Phone Number _____ Cell _____ Work _____

Is it OK to leave a message at the numbers listed? YES NO

Emergency Contact _____ Emergency number _____

Parents Name, if a Child/ Adolescent _____

Insurance Subscriber (individual whose insurance is providing the coverage) _____

Subscriber's DOB _____ Subscriber's ID# _____

Effective Date _____ Subscribers Group Number _____

Subscribers Employer _____ Insurance Company Name _____
(Your mental health benefits may be administered by a different company than your card reflects)

Insurance Claims address: _____
City State Zip

You agree to allow me to file/process for payment through your insurance on your behalf? YES NO

Is this an EAP referral/Visit? YES NO Authorization # _____

Have you been preauthorized for this visit? YES NO Is Preauthorization required? YES NO

******It is your responsibility to contact your insurance company for authorization prior to the initial visit. ******

Do you have the authorization number? YES NO Please list number of sessions authorized _____

Do deductibles apply for your visits? YES NO Amount _____

(Note: medical and mental health deductibles may differ and be calculated separate)

Has the deductible been met? YES NO If not the deductible will be charged until met.

Do you a co-payment? YES NO Amount or percent? _____

Are your sessions limited or unlimited? YES NO _____ # of session per year, if limited.

Informed Consent Information & Permission for Treatment

Please review the information requested below. Your signature will indicate that you understand and accept the information contained in the Informed Consent Information and Permission for Treatment.

Your information, including your status as our client is kept strictly confidential. I respect your legal right to confidentiality and will protect your information with the proper care. Identifying information will not be released without your permission. All records will be maintained in a confidential manner. Consent forms will be required for the release of any information. State and Federal laws may require the release of information without written or verbal consent in the following specific situations: 1. Medical or Mental Health Emergencies 2. Clients become a danger to themselves (Suicidal thoughts/behaviors/attempts, severe depression, etc.) 3. Clients become a danger to others (Homicidal thoughts/behaviors/attempts). The person threatened and the police will be notified. 4. Any report or suspected child abuse or neglect (Physical or sexual). 5. Any report or suspected domestic violence. 6. A court order directing the release of information. 7. Any litigation initiated by the client related to treatment. 8. Any abuse of the elderly, with mental illness or who cannot care for themselves properly. 9. For children under 18 years of age, videotaping is done to ensure the safety and welfare of the child and/or for educational purposes.

Fees are due at the time of service delivery. Prices may be reduced for shorter time periods. Cash, check or credit cards are accepted forms of payment. Clients are responsible for payment of delivered services. We will make an attempt to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility including, but not limited to: deductibles, co pays, and any fee not covered by your insurance provider.

At times the need arises for extended sessions. People often report significant benefit from sessions lasting 1 1/2 hours. We are excited to offer these sessions as an added service to you. Insurance carriers often cover the first part of these sessions and the client is then responsible for the other half.

Service	Time/ Minutes	Cost
Initial Intake	60	\$125
45 minute Individual session*	45-50	\$100
45 minute session with a family	45-60	\$125
Group Session per Individual	90	\$40
Group Session per Couple	90	\$45
Other Fees Associated with Services Not Paid by Insurance		
“No Show” Fee		\$100
“Group No Show” Fee		\$50
“Late Cancel” Fee (24 hours or less)		\$65
Return Check Fee		\$30
Letter Writing		\$35/page
Court Preparation and Court Reports		\$75/hour
Court Appearance *** 120 minutes minimum	Minimum	\$300
Telephone Consultation	15	\$25

By signing this form I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed.

We require payment at the time of service. If you have a deductible or co-pay, payment is expected at the time of service. A \$5.00 charge will be assessed to your account if your payment is not received on that day.

Center for Child and Family Counseling, PLLC

As a courtesy to you, our billing department will assist you in submitting your insurance forms. If, however, your insurance company does not pay the anticipated amount, you are still responsible for the total amount of the bill. Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment. Ultimately, it is your responsibility to know the benefits of your policy and any changes that may arise.

If your insurance company requires a deductible, Center for Child and Family, PLLC will accept a payment of \$85.00 for each session until that deductible is met. This payment is also due at the time of each session.

In the event your account is not paid within 90 days or your balance exceeds \$500, collection proceedings will be instituted. If we have to refer your account to collections, you will be responsible for all costs of collections including reasonable collection agency fees, attorney fees, and court costs.

If you have insurance, please understand that this is an agreement between you and your insurance company. ***If your insurance company requires an authorization for your visits, please make sure that you have obtained this authorization prior to your first appointment. If your insurance company denies your visits for any reason, you will be responsible for the full fee of each of these visits at the rate listed above.***

I have read and understand the above statements and agree to be bound by the terms in this policy. I have had the opportunity to ask questions about anything in this policy and have had my questions answered to my satisfaction.

I consent to release any personal or clinical information required to process my claim to my insurance provider listed on the back of this form. I also authorize any payments made by my insurance company to be paid directly to Center for Child and Family Counseling, PLLC. This form will be considered a signature on file for all future insurance claims. This release will expire 1 year from the date of your last appointment.

I understand and agree to the limits of confidentiality as indicated above. I agree to hold Center for Child and Family Counseling, PLLC harmless for any loss, cost or damages sustained by my spouse, child or me. By signing this form, I hereby authorize Janet Vessels, M.S. LPCC or the staff of the Center for Child and Family Counseling, PLLC to assess, diagnose and treat mental health and or substance abuse problems for myself, my family and or my child.

This acknowledges that I have receive a copy of the "Notice of Privacy Practices" for and received a copy for my files. **Y** **N**

_____ **Date** _____

_____ **Client Name-Print Please**

_____ **Client Signature**

_____ **Parent Signature/Adol/Child**

Credit Card Authorization Form

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE.

Our primary goal is to take care of all expenses at the time of services. We keep a copy in your confidential record for the reasons below.

- 1. To bill any unpaid charges that may accrue as a result of having a deductible, co-payment, or coinsurance and or any other fees agreed upon that were not paid at the time of service delivery. Also to collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program or managed care company.**
- 2. To bill any Fail to Keep Appointment Fees or Cancellation Fees that are not paid by you through regular contact or billing.**
- 3. Any NSF or Returned Unpaid Check amount plus returned check fees from your bank.**

By providing the information below you agree to allow the Center for Child and Family Counseling, PLLC to bill the above mentioned fees and any other agreed upon fees located in the Informed Consent or Fee Schedule not paid by you in person, even if we are unable to contact you. You also agree that a \$5.00 per charge fee will be added for using your card for unpaid fees that are not paid through a written or verbal request. You also agree that all NSF or unpaid checks will be charged an extra \$30.00 charge plus the card fee. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card.

Name exactly as it appears on card _____

Type of Card (Visa and MC ONLY) Visa MasterCard

Card Number _____

Expiration Date Month _____ Year _____

Security Number (3 digits back of card) _____

Is billing address for card the same as home address? Yes No (If no fill in below)

Phone number for card Same as Home Phone Cell Phone Other _____

Client or Parent Signature _____

Date _____

Questionnaire for Primary Caregivers

Date: _____ Person Completing Form: _____ Relationship to Child: _____
Child's Name: _____ Date of Birth: _____
Mother's Name: _____ Date of Birth: _____
Mother's Occupation and Work Hours: _____
Father's Name: _____ Date of Birth: _____
Father's Occupation and Work Hours: _____
Email Addresses for Parents: _____
Child's School: _____ Teacher: _____ Grade: _____ Phone # _____
Who has Custody of the child? _____ (please provide copy of custody order for the file)

List all those living in the child's home:

Name	Relationship	Age/School/ Occupation

List other persons closely involved with the child but not living in the home:

What are your concerns about your child that made you bring him/her to counseling?

DEVELOPMENTAL HISTORY

Describe any difficulties mother experienced during pregnancy: (emotional status during pregnancy, excessive nausea, serious illness, drug or alcohol use):

Describe any major difficulties during labor or delivery: (Mother's health at time of delivery or prenatal complications type of delivery)

Were child's developmental milestones met on time (Walking, talking, toilet training, etc.)? _____

Please describe how your child gets along with other family members:

How is your child disciplined and by whom?

Please describe any concerns about your family listed below:

Health concerns:

Mental Illness:

Alcoholism/drug addiction:

Death in family:

Job loss:

Marital Difficulties:

Physical/sexual/emotional abuse:

Other:

Were there any major disruptions in your child's life? (deaths/ losses-people or pets, absences, etc., problems in separation with caretakers, day care, preschool, school experiences, homelessness, disasters/catastrophic events):

Describe your child's personality:

Describe your child's favorite activities:

What do you like best about your child? _____

How you spend time with your child (activities or things you do together)? _____

SYMPTOMS

Please check if your child is experiencing any of the following:

SYMPTOM	FREQUENTLY	SOMETIMES	PLEASE DESCRIBE
Difficulty sleeping			
Nightmares			
Startles easily, very jumpy			
Shows little or no emotion			
Unusually clingy			
Afraid to be alone			
Avoids certain people, things, place			
Difficulty concentrating or focusing			
Stomachaches, headaches			
Little sense of joy or happiness			
Cries a lot			
Talks about or has attempted suicide			
Hurts self on purpose			
Change in eating habits			
Frequent tantrums or irritability			
Increased aggression			
Hurts animals on purpose			
Fascinated with fires or sets fires			
Hides food			
Wets bed or soils self			
Refuses to go to the bathroom			
Urinate in place other than bathroom			
Washes self excessively			
Masturbates excessively			
Touches other inappropriately			
Engages in risky behaviors			
Abuses alcohol/drugs			
Lies/steals			
Has unusual tics or mannerisms			
Doesn't trust others			
Poor peer relationships			
Says does not self/ body			

Are there any other symptoms or behaviors you are concerned about:

Mother's Background:

Where were you raised and by whom? Describe past/current relationship with your parents:

List brothers and sisters, their ages, whereabouts, current relationship you have:

Describe any of the following you/your family experience during childhood and how it affected you (physical/sexual abuse, neglect abandonment, spousal abuse divorce, other trauma)

Who were you closest to when you were a child? Describe the relationship with that person:

How were you disciplined and by whom?

Describe the happiest time/experience you recall from your childhood:

Describe the saddest time/experience you recall from your childhood:

Describe if you or any relatives have ever had any of the following:

Serious illness: _____

Depression/Bipolar Disorder: _____

Anxiety Disorder: _____

Obsessive –Compulsive Disorder: _____

Learning Disability/ ADHD: _____

Eating Disorder: _____

Alcoholism/Drug Abuse: _____

Criminal Conviction: _____

Please add any other information about your background that you feel is important:

Father's Background:

Where were you raised and by whom? Describe past/current relationship with your parents:

List brothers and sisters, their ages, whereabouts, current relationship you have:

Describe any of the following you/your family experience during childhood and how it affected you (physical/sexual abuse, neglect abandonment, spousal abuse divorce, other trauma)

Who were you closest to when you were a child? Describe the relationship with that person:

How were you disciplined and by whom?

Describe the happiest time/experience you recall from your childhood: _____

Describe the saddest time/experience you recall from your childhood:

Describe if you or any relatives have ever had any of the following:

Serious illness: _____

Depression/Bipolar Disorder: _____

Anxiety Disorder: _____

Obsessive –Compulsive Disorder: _____

Learning Disability/ ADHD: _____

Eating Disorder: _____

Alcoholism/Drug Abuse: _____

Criminal Conviction: _____

Please add any other information about your background that you feel is important:
