

KILLEEN

COUNSELING SERVICES, LLC

7700 Clayton Rd, Ste 303
St. Louis, MO 63117

Phone: (314) 720-2710
Fax: (888) 501-1330

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|-------------------------------------------------------------|
| For Office use: Diag. Code _____ Diag: Receipt _____ |
|-------------------------------------------------------------|

Today's Date: ___/___/_____

PERSONAL INFORMATION

Full Name: _____ Date of Birth: _____ Soc. Sec. # _____

Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Preferred to be contacted :(____) _____

Education: High School [] College [] Other _____

Occupation: _____ Employer: _____ Phone # _____

Religious/ Church Affiliation: _____ Active [] Moderate [] Inactive []

Relationship(s) you can depend on for help at present time: _____

Personal character traits and/or beliefs that you can rely upon right now

Referred by: _____ Address: _____ Phone # _____

FAMILY INFORMATION

Marital Status: Single [] Married [] How long? _____

Spouse's Name: _____ Phone # _____

Divorced [] Separated [] Widowed [] Common-law []

Previous Marriage(s): Name(s) _____ Duration _____

Spouse's Education: High School [] College [] Other _____

Spouse's Occupation: _____ Employer _____ Phone # _____

Children (please list names and ages): _____

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HEALTH INFORMATION

Rate your current health: Very good [] Good [] Average [] Declining []

List current medical problems/diagnosis(s)/medications and dosages:

Primary Physician: _____ Phone: _____

SPOUSE HEALTH INFORMATION

Rate your current health: Very good [] Good [] Average [] Declining []

List current medical problems/diagnosis(s)/medications and dosages:

Primary Physician: _____ Phone: _____

PREVIOUS COUNSELING HISTORY

Have you previously sought counseling? Yes [] No []

Therapist _____ Profession _____ From _____ To _____

Therapist _____ Profession _____ From _____ To _____

Describe what was helpful and unhelpful in the way your previous therapist(s) worked with you?

COUNSELING AGREEMENT

In the interest of full disclosure about the counseling you will be receiving, please read through this agreement, sign and date it at the bottom.

Description of Counseling

Counseling is engaging in an ethical interpersonal relationship with a trained therapist in order to resolve problematic relational issues, behaviors, emotions, thoughts, and sensations in the body. Therapists will first seek to understand the client(s) motivation for seeking counseling in order to clarify and establish an agreement on goals they can pursue together. To achieve agreed upon goals, our therapists will use a diversity of therapeutic modes and strategies. These therapeutic modes and strategies will be in line with our counseling philosophy, which is an integration of evidence-based counseling theories/techniques and biblical wisdom. Although guided by a Christian worldview, our counselors will be sensitive to your religious/cultural differences and perspectives.

Qualifications of Counselor

Clay Coffee received his Ph.D. in Family Therapy from Saint Louis University and his Master of Arts in Counseling and Masters of Divinity from Covenant Theological Seminary. Prior to joining Killeen Counseling, Clay served as a pastor and counselor in church-based settings for over fifteen years working with couples and families in conflict, providing premarital education and counseling, and caring for individuals and families walking through divorce, remarriage and a variety of other issues. Clay is currently a Supervised Marriage and Family Therapist and Counselor in Training in the state of Missouri and is practicing under the supervision of Ed Killeen, LPC (License # 2009032622) and Ellen Ranney, PhD, LMFT (License #30095).

Risks and Benefits of Counseling.

Counseling has both benefits and risks. Risks may include experiencing increased relational and personal distress. This may include experiencing uncomfortable feelings such as guilt, sadness, anxiety, frustration and helplessness due to discussing and experiencing difficult issues in your life. The counseling relationship also requires an investment of your time and finances while there is no guarantee that your problems will be resolved. However, counseling has been shown to have benefits for the individuals, couples, and families who engage in it. Counseling often leads to a significant reduction in distressing feelings, an increased satisfaction in interpersonal relationships, greater personal awareness and insight, a restored sense of meaning, direction and agency in life, and the easing or complete resolution of specific problems.

Referral Policy/Disclaimer

Clients will be referred to outside resources when it is determined that the treatment required is beyond the scope of care available here at Killeen Counseling. Though we are committed to making the best referrals possible for your particular situation, we are not liable for any services provided or not provided by the referred professional.

Confidentiality

A key part of the counseling relationship is that your participation is kept confidential. In general, this means that we will not disclose any verbal or written information about you, or the fact you are a client. Knowing your personal information will not be disclosed is an important part of the counseling relationship. However, it is also important that you not only understand but also agree to some important ethical and legal limits to confidentiality. Your signature below will indicate your agreement with the following limitations to confidentiality:

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- 1) If you sign a release form authorizing us to divulge part or all treatment information,
- 2) If you intend suicide,
- 3) If you intend homicide,
- 4) If we believe that a child, elderly person, or person with disability is being abused,
- 5) When consulting with supervisors or other professionals regarding your case,
- 6) When the Court determines information subpoenaed in a legal proceeding be disclosed.

If you are threatening bodily harm to yourself or others, we are ethically and legally required to take protective actions. These actions may include notifying the potential victim or victim's family, contacting the police, seeking your hospitalization or recruiting family or friends for your safety. If we have reason to suspect that a child, elderly person, or person with disability, is being abused or neglected, we must file a report with the appropriate state agency. If any of these situations arises during the course of counseling, we will seek to discuss them with you before taking any action. In situations where a release of information is necessary, we will strive to protect your confidentiality to the highest degree possible.

All our counselors participate in peer supervision and consultation. This practice meets ethical and legal standards of our profession and facilitates both the continued development of our therapists and your quality of care. See our Notice of Privacy Practices (pp. 7-10) for more details regarding confidentiality.

Session Length & Fee for Counseling

Counseling sessions usually run 50 minutes. The standard hourly fee for Clay Coffee, PhD, SMFT, CIT is \$90. Additional time is billed to the quarter hour. Our practice is to ask clients to pay as we proceed. We accept MasterCard, Visa, Discover, and American Express, as well as personal checks. Please provide your means of payment at the beginning of each session.

Where insurance is applicable, we will give you a diagnostic receipt that you may file with your insurance company who will reimburse you in accordance with your policy. Please note that: a) some companies do not reimburse for our services and, b) insurance coverage policies are often changing. This means you are ultimately responsible to ascertain coverage and initiate filing diagnostic receipts. Such receipts are given upon request. They will include a diagnosis in accord with the Diagnostic and Statistical Manual of Mental Disorders V.

Missed Appointments

Your cooperation in keeping scheduled appointments is expected. To cancel an appointment, you are required to notify Clay by phone (314-720-2710 ext.5) or email (clay@killeencounseling.com) 48 hours in advance. If you cancel or do not keep an appointment without appropriate (48 hours) advance notice, you will be charged the full hourly fee for the time you reserved for an appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges. If you have any questions at all, please feel free to ask your therapist.

Rights as a Client

- 1) You are entitled to information about any procedures, methods of counseling, techniques and possible duration of counseling.
- 2) You have the right to end counseling at any time without any moral, legal or financial obligations other than those already accrued.
- 3) You have the right to expect confidentiality within the limits described by this counseling agreement and within our Notice of Privacy Practices statement.
- 4) You have the right to request in writing the release of your records to any person or agency.
- 5) You have the right to authorize your counselor to consult with another professional about your counseling in writing.
- 6) You have the right to file a grievance in writing with the Privacy Officer (see Notice of Privacy of Practice) if you have concerns that your rights as a client have been violated.

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I have read and agree to the above counseling agreement statement and procedures and have reviewed a copy of Killeen Counseling Services, LLC Notice of Privacy Practices (see pp. 7-9).

Signature of Clients

Printed Name of Clients

Date

Signature of Clients

Printed Name of Clients

Date

Signature of Counselor

Date

Consent to Email Communications (Optional)

I/we recognize that email is not a secure means to transmit data. I voluntarily waive my rights provided by federal and state laws regarding confidentiality in order to send to, or receive communications (and/or invoices) from Killeen Counseling Services, LLC via email. I voluntarily give my permission and will not hold Killeen Counseling Services, LLC and my therapist therein legally responsible for the transmission of this data.

Client Signature(s):

_____ Date _____

Client Signature(s):

_____ Date _____

Email Address(s): _____

Counselor Signature

_____ Date _____

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Notice of Privacy Practices (7-9)

As you begin counseling, you may wonder:

How can medical information about you be used?

How can you obtain access to such information?

For answers to these and other information regarding our privacy practices please read the information below. Your counselor will also review this information in brief during your first appointment.

OUR COMMITMENT TO YOUR PRIVACY

Killeen Counseling Services, LLC is dedicated to maintaining the privacy of your health information. In conducting our practice, we will create records regarding you and the treatment and services we provide to you. This may be information about your past, present or future health or conditions, or the tests and treatment you got from us or from others, or about payment for healthcare. There may also be other kinds of information that go into your healthcare record here.

PRIVACY AND THE LAWS

Because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of health information that identifies you.

We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information.
- Your privacy rights in your health information.
- Our obligations concerning the use and disclosure of your health information.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS *With your signed consent:*

Below, we have listed some of the reasons why we might use or disclose your health information with some examples. Not every use or disclosure is discussed, but all of the ways that we are allowed to use and disclose information falls into one of these categories.

For Treatment: Our practice may use your health information to treat you. This may include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services. Many of the people who work for our practice may use or disclose your health information in order to treat you or assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your health information to other health care providers for purposes related to your treatment.

For Payment: Our practice may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment so that your insurer will cover, or pay for, your treatment.

For Health Care Operations: Our practice may use and disclose your information for our practice operations to evaluate the quality of care you received from us.

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For Other Uses in Healthcare:

- We may use or disclose your health information to contact you and remind you that you have an appointment for treatment or medical care.
- We may use or disclose your health information to provide you with information about or recommendations of possible treatment options or alternatives that may interest you.
- We may use or disclose your health information to a group health plan, health insurance issuer, HMO or plan sponsor.
- We may release health information about you to a friend and/or family member who is involved in your care.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your health information for the purposes described in the authorization. Please note, we are required to retain records of your care.

We can use or disclose health information about you without your authorization when there is an emergency, when we are required by law to treat you, or when we are required by law to use or disclose certain information. We may use or disclose your health information without your authorization in any of the following circumstances:

- When it is required by federal, state or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect or domestic violence;
- When disclosing information for judicial and administrative proceedings;
- When disclosing information for law enforcement purposes;
- When we believe in good faith that the disclosure is necessary to avert a serious health or safety threat;
- When disclosure is necessary for specialized government functions;
- When disclosure is necessary to comply with worker's compensation laws or purposes.

PLANNED USES OR DISCLOSURES TO WHICH YOU HAVE AN OPPORTUNITY TO OBJECT:

We may use or disclose your health information with anyone you choose – family, close others, clergy - unless you affirmatively object to or otherwise restrict a particular release, as long as it is not against the law. You may direct your objections or restriction in writing to your caregiver or to the Privacy Officer listed in this Notice.

AN ACCOUNTING OF DISCLOSURES:

When we disclose your health information we may keep some records of when we sent it, what we sent, and to whom we sent it. You can get an accounting (a list) of many of these disclosures for the last six years, but not before not before January 1, 2010. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

You have the following rights regarding the health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. While we are not required to agree to your request, if we do agree we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Killeen Counseling Services, LLC in order to inspect and/or obtain a copy of your health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of denial. Instead of providing the health information you requested, we may provide you with a summary or explanation of the information as long as you agree to that and to the cost in advance.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to Killeen Counseling Services, LLC. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the health information kept by or for the practice; (c) not part of the health information which you would be permitted to inspect and copy; or (d) not created by our practice. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your health information.
5. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Killeen Counseling Services, LLC.
6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer as listed below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Privacy Officer
Killeen Counseling Services, LLC
7700 Clayton Rd, Ste 303
St. Louis, MO 63117
Office: (314) 720-2710
Fax: (888) 501-1330