

SECURE

COUNSELING CLINIC

CLIENT INTAKE INFORMATION PACKET



The information in this packet is used by your clinician for administrative purposes, and more importantly, to become familiar with your presenting concerns, history, and possible areas of mental health and wellness to be worked on in your clinical counseling services. Please answer as thoroughly as you can, as if you are communicating with your counselor before your therapy actually begins. This packet information is stored with HIPAA compliant measures.

Date _____

Client Name: _____ Date of Birth: _____

If applicable: Minor(s) (<18 years old) First and Last Name (s):

Address: _____
Street City State Zip

How would you describe your occupation/title/position? _____

Telephone: Home () _____
Cell () _____
Work () _____ May I contact you at work? _____
Email _____ (REQUIRED FOR SCHEDULING AND BILLING)

Please list all members of your household:

Name Relationship Date of Birth Employer/School

Adults:

1. _____
2. _____

Children/Minors:

Name	Male/Female	Circle one	DOB/Age	School
3. _____		Bio/Step/Foster/Adopted	_____	_____
4. _____		Bio/Step/Foster/Adopted	_____	_____
5. _____		Bio/Step/Foster/Adopted	_____	_____
6. _____		Bio/Step/Foster/Adopted	_____	_____
7. _____		Bio/Step/Foster/Adopted	_____	_____
8. _____		Bio/Step/Foster/Adopted	_____	_____
9. _____		Bio/Step/Foster/Adopted	_____	_____
10. _____		Bio/Step/Foster/Adopted	_____	_____

Other (in or out of household, e.g. adult children, seniors who live in the home, etc):

11. _____
12. _____
13. _____

PLEASE COMPLETE PAGES 2-7 FOR EACH PERSON IN TREATMENT



(e.g. If treating a couple, one set of contact and background information for each partner; if treating a family, one set of information for each parent and child).

Name of Person (regarding answers in pages 2-7): _____

Currently, I am: (Circle one)

- ___ MINOR CLIENT (<18 years old)
___ Single Adult
___ Coupled, but not married
___ Married
___ Divorced
___ Separated
___ Widowed

If any above except minor child or "single":

Wedding date: _____

If applicable, separation/divorce date: _____

If applicable, date of Spouse's death: _____

Have you ever been married before? YES NO

If yes, please explain your relationship history:

Current Spouse's Name _____ Date of Birth: _____

If applicable, Date of Death: _____

Cause of Death: _____

Address (if different from yours) _____ Employer _____

Telephone: Home () _____ Work () _____ May I contact them at work? _____

Who may we contact in the event of an emergency?

Name: _____

Phone number: _____

Relationship: _____

Please describe briefly the concern or situation, which led you to seek counseling services at this time:

How long has this been a concern? _____

Have you experienced this type of concern before (circle one)? YES NO

If so, when? _____

Have you had any significant events - either positive or negative - occur recently or within a notable amount of time, such as job/school changes, death(s), changes in finances, living situation, illness, infertility, etc?

Medical Doctor's Name (general physician or other doctor you regularly visit):



Do you regularly have physical wellness check-ups? YES NO

If you have noticed any recent changes in the following areas, please circle those changes:

- A) vision, hearing, coordination, balance, strength, speech, memory, or thinking
B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

Are you currently seeing a counselor, therapist, psychologist, or psychiatrist? YES NO

If yes, who? _____

If there are other types of professionals you are currently consulting with, (e.g. school counselors, occupational therapists, nutritionists, chiropractors, acupuncturists, massage therapists, internal or integrative medicine, specialized medicine doctors) which types of professionals?

Have you ever had counseling before? YES NO
If so, when and why?

Was it helpful? _____ If not, why not?

Have you ever had medication prescribed for psychiatric or emotional difficulties? YES NO
If so, please list:

Did you find these medications helpful? _____ If not, why not?

Have you ever been physically, sexually, emotionally abused? YES NO

If yes, briefly describe (optional):

Have you (person whose background this regards, whether adult or child) experienced any of the following (check any that apply):

- ___ Stressful prenatal experience prior to your own birth (maternal emotional stress, infection, preeclampsia, etc.)
___ Difficult birthing (e.g. oxygen deprivation, abnormal presentation, prolonged labor, etc.)
___ Prematurity/Newborn Intensive Care Unit (NICU)
___ Early hospitalization in childhood/adolescence
___ Domestic or international adoption and/or foster care

If adopted, what is the "Forever Family," "Gotcha Date," or date of formalized adoption? _____

Please briefly explain circumstances of any above checked items.

Have you ever been hospitalized for mental or emotional problems? YES NO

If yes, when and where?

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Are you experiencing any issues related to sexuality (i.e. desire, performance, sexual identity, pornography use, etc.)



YES NO

If yes, please explain:

Have you ever attempted suicide? YES NO

If yes, how and when: _____

Are you suicidal now? YES NO

How often do you drink alcohol? _____
Have you ever been arrested for driving under the influence (DUI)? YES NO

Do you smoke or use tobacco? YES NO
If yes, how much? _____

Do you use recreational drugs? YES NO
If yes, what drugs do you use and how often?

Do you have any concerns about alcohol or drug usage by members of your family? YES NO
If yes, please explain:

Do you feel you or a family member have any problems with gambling or spending/shopping? YES NO
If yes, please explain:

Are you currently involved or do you expect to be involved in any court related matters? YES NO
If yes, please describe _____

Have you currently or in the past restricted food consumption, binged on food, or purged/vomited/taken laxatives? YES NO
If yes, please describe _____

Have any other biological relatives had relational or individual mental health concerns - psychiatric or emotional difficulties (circle one)?

YES NO

If so, which relatives and what kind of concerns?

Presenting concerns: (check all that apply - if attending couples or family counseling, please put initials of each person next to the problems that apply if you would like to note it about another person.)

- | | | | |
|------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> very unhappy | <input type="checkbox"/> impulsive | <input type="checkbox"/> parenting problems | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> irritable | <input type="checkbox"/> stubborn | <input type="checkbox"/> stealing | <input type="checkbox"/> anger |
| <input type="checkbox"/> temper outbursts | <input type="checkbox"/> panic attacks | <input type="checkbox"/> repetitive/ritualistic behaviors | <input type="checkbox"/> loneliness |
| <input type="checkbox"/> withdrawn/isolation | <input type="checkbox"/> lying | <input type="checkbox"/> grief | <input type="checkbox"/> frustration |
| <input type="checkbox"/> daydreaming | <input type="checkbox"/> mean to others | <input type="checkbox"/> employment problems | <input type="checkbox"/> depression |
| <input type="checkbox"/> fearful | <input type="checkbox"/> destructive | <input type="checkbox"/> financial stress | <input type="checkbox"/> pornography use |
| <input type="checkbox"/> worry | <input type="checkbox"/> trouble with the law | <input type="checkbox"/> legal problems | <input type="checkbox"/> headaches |
| <input type="checkbox"/> overactive | <input type="checkbox"/> health problems | <input type="checkbox"/> violence | <input type="checkbox"/> insecurity |
| <input type="checkbox"/> slow | <input type="checkbox"/> self-mutilating | <input type="checkbox"/> eating problems | <input type="checkbox"/> self-control |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> stressed out | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> can't concentrate | <input type="checkbox"/> stomach/bowel problems | <input type="checkbox"/> memory loss | <input type="checkbox"/> no ambition |
| <input type="checkbox"/> distractible | <input type="checkbox"/> relationship problems | <input type="checkbox"/> sexual problems | <input type="checkbox"/> lack of energy |
| <input type="checkbox"/> marital problems | <input type="checkbox"/> divorce | <input type="checkbox"/> separation | <input type="checkbox"/> affair |
| <input type="checkbox"/> problems w/ ex-spouse | <input type="checkbox"/> stress | <input type="checkbox"/> bed wetting | <input type="checkbox"/> no joy |
| <input type="checkbox"/> work problems | <input type="checkbox"/> can't make decisions | <input type="checkbox"/> problems with friends | <input type="checkbox"/> tiredness |
| <input type="checkbox"/> school problems | <input type="checkbox"/> shyness | <input type="checkbox"/> drug use | <input type="checkbox"/> problems with children |
| <input type="checkbox"/> lacks initiative | <input type="checkbox"/> undependable | <input type="checkbox"/> strange behavior | <input type="checkbox"/> alcohol use |
| <input type="checkbox"/> career choices | <input type="checkbox"/> social problems | <input type="checkbox"/> strange thoughts | <input type="checkbox"/> hair pulling |
| <input type="checkbox"/> problems with parents | <input type="checkbox"/> chronic pain | <input type="checkbox"/> crying spells | <input type="checkbox"/> seizures |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> emotional abuse | <input type="checkbox"/> verbal abuse |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> homicidal thoughts | | |

Explain any further symptoms or remarks about your presenting concerns:

What are your goals for treatment (what do you want to accomplish with counseling)?

Is there anything else you feel is important for your therapist to know?

DEMOGRAPHIC INFORMATION

Ethnicity:

- | | | |
|-------------------------------------------------|-----------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Caucasian/White | <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic/Latino | |

Combined Household Income (Yearly):

- | | | |
|----------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Less than \$15,000 | <input type="checkbox"/> \$30,000 - \$49,999 | <input type="checkbox"/> \$70,000 - \$99,999 |
| <input type="checkbox"/> \$15,000 - \$29,999 | <input type="checkbox"/> \$50,000 - \$69,999 | <input type="checkbox"/> \$100,000 and up |

Education of Adults in Household (put initials of each adult if more than one):

- | | | |
|-----------------------------------------------|---------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Associate's Degree | <input type="checkbox"/> Doctorate |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Trade/Specialty |
| <input type="checkbox"/> Some College | <input type="checkbox"/> Master's Degree | <input type="checkbox"/> Other: _____ |

School District (SD) of Children/Teens: _____

Do you consider yourself spiritual? YES NO

Comments: _____

Do you currently express this spirituality through religious practice (Judaism, Christianity, Hinduism, Buddhism, etc)? YES NO

Comments: _____

Would you like spirituality included in your counseling? YES MAYBE NO

NOTE: Secure provides clinical counseling, and discussion of religion/spirituality are discussed only when initiated by you, if you desire that to be a part of your treatment.

How did you hear about Secure Counseling Clinic or your counselor (check all that apply)?

- | | | |
|----------------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Google | <input type="checkbox"/> Yahoo | <input type="checkbox"/> TherapySites.com |
| <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Facebook | <input type="checkbox"/> Agency/Organization |
| <input type="checkbox"/> Twitter | <input type="checkbox"/> Linked In | (which one? _____) |
| <input type="checkbox"/> Secure Counseling website | <input type="checkbox"/> A Professional | <input type="checkbox"/> Pastor, Rabbi, Church, etc. |
| | | (which one? _____) |
| <input type="checkbox"/> Individual (who? _____) | <input type="checkbox"/> Other (please specify) | _____ |

If applicable, do I have permission to thank the person who referred you? (circle one) YES NO



INFORMED CONSENT FOR TREATMENT

It is important that you, as the client, are fully informed about the counseling services you will be receiving before deciding to begin therapy. Your signature below indicates that you have received, read, and understand our policies. You are making an informed decision about entering into counseling.

1. I understand that I have certain rights as a client, and those rights are being reviewed with me.
2. I understand that my counselor is licensed by the state of Kansas as a Licensed Clinical Professional Counselor and by the National Board of Certified Counselors. I also understand that s/he receives private and group clinical consultation for the purpose of pursuit of professional excellence. I give permission to allow the consultants of my counselor access to case summary without identifying information about me for the purpose of maximizing the effectiveness of my therapy.
3. I also give permission for my counselor to present my case during consultation for the purpose of case management, continuing education, and training. The specific information about my practitioner’s consultation is covered in the Authorization for Consultation.
4. I understand that the counselor is bound by the Code of Ethics set forth by the American Counseling Association (ACA) and several other professional governing boards, and I can access a copy of these ethics at any time at www.counseling.org.
5. I understand that, according to Kansas and Missouri law, my counselor has an obligation:
 - 1) to warn others of life threatening concerns should it become necessary,
 - 2) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and,
 - 3) to provide information in legal cases when under court order/subpoena, and
 - 4) to release information from my file when I request this using a written release.
 I understand the exceptions to client confidentiality, and I agree to them.
6. I understand that under Kansas law, my counselor is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my counselor will discuss this process with me at any time if I so request.
7. I understand that there can be risks (such as emotional exploration) and benefits (such as emotional growth and self-awareness) associated with counseling and have discussed those with my counselor. I understand that no promises have been made to me as to the results of treatment or of any procedures provided.
8. I understand that I may leave counseling at any time and agree to discuss the termination of therapy at a regular session, rather than by phone.
9. I understand that I have the right not to sign this form; however, I also understand that doing so will make me ineligible to receive any services from my counselor at this time. If this is your choice, it can be arranged for you to receive referrals for other practitioners.

My signature below indicates that I give my full informed consent to receive counseling services from this site.

Signature _____ Date _____ Signature _____ Date _____
 Signature _____ Date _____ Signature _____ Date _____



AUTHORIZATION FOR CONSULTATION, PRACTICE WILL, AND OPTIONAL VIDEO/AUDIO RELEASE

Consultation:

Your counselor has reached the highest level of licensure available for practicing clinicians (LCPC), therefore are not required to be supervised. Because we believe that the integrity of our professional training requires the occasional consultation with other clinicians, we ask your permission to disclose information about your case to the below listed professionals. Secure Counseling Clinic and its counselors believe that these practices also contribute to the high quality of professional services provided for you, our valued client. All identifying information about you and your family is kept confidential, and your counselor reveals only relevant case information for discussion of best practice and appropriate treatment.

The therapy offered to you is delivered by a Licensed Clinical Professional Counselor in the State of Kansas. Vanessa Knight, LCPC (#2330), NCC (#270119), CCMHC and Ben Taussig, LCPC (#2344), NCC (#270122). Both Ben Taussig and Vanessa Knight consult with one another regarding Secure Clinic cases, as practicing partners. Both partners occasionally participate in collegial consultation groups with other private practice clinicians for the purpose of continuing education and the pursuit of professional excellence.

Practice Will:

Should either counselor of Secure become unavailable, incapacitated, or deceased, the co-owner and partner of that counselor will assume responsibility for your case, files, treatment and referrals to additional/alternative professionals. Your file will be maintained by Secure for a total of seven (7) years after the final date of treatment. Minor files are maintained for 7 years after the child's 18th birthday or the final date of treatment, whichever is later.

I give permission to allow the partner and consultant(s) of my counselor access to my client file for the purpose of guiding my treatment and my counselor's continued training in his/her field. I understand the transfer of care, should my counselor become unavailable, incapacitated or deceased. I understand that I have the right not to sign this form. However, I also understand that doing so will make me ineligible to receive any services from my counselor at this time. If this is your choice, it can be arranged for you to receive referrals for other practitioners.

My signature below indicates that I agree to the aforementioned arrangements. **To be signed by all legal adults.**

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

_____ (Optional, Initial Here) I give permission to allow my counselor to make audio or video recordings of counseling sessions for my counselor to replay session interactions in order to further help me/my family or for consultation/training purposes (portions of these recordings may be reviewed by the counselor's consultants/supervisor(s) as part of his or her professional continuing education or certification requirements). **All recordings are destroyed following viewing and are not kept as a part of formal client files at any time.** All recordings are treated with the same ethical concern as confidential records. I give permission for my counselor to present my case and segments of audio or video during group consultation/supervision for the purpose of excellence in case management and training.

WAIVER OF MEDICAL AND PSYCHIATRIC CONSULTATION

I understand that under the provisions of Kansas law KSA 65-6404 (b) (3), my counselor is/are required to consult with a primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that s/he may have observed while working with me or my minor children (*under 17 years*).

Please print the names of any family members to attend counseling:

Name of ADULTS (printed):	Name of MINOR CHILDREN (printed):

By signing below, I am indicating that I waive such mandated consultation and that I do not wish for my counselor to contact my/our physician(s) or psychiatrist(s).

I understand that, although I have waived my right for consultation, as concerns arise, my counselor may approach me again to discuss symptoms of concern. If there is a need for further consultation, I will be asked to complete an *Authorization for Release of Information* to allow for such consultation.

In the event that my counselor addresses the need for further consultation, and I or my minor child(ren) do not currently have a primary care physician or psychiatrist, I acknowledge that my counselor may recommend that I seek medical consultation or provide me with appropriate referrals.

I understand that I have the right not to sign this waiver and that doing so provides my counselor the full right and requirement to make appropriate consultation. I am also aware that this waiver will become part of my client record.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____



Financial Contract

The financial investment you make in your counseling is reflective of your commitment to change and growth in your therapy work.

We offer a discounted fee structure (commonly known as a “sliding scale”) of \$100-150, depending on your family household income and the number of dependents living in your household.

Insurance Claims

If you have a Health Savings Account or a flexible benefits account, receipts are generally 100% reimbursable through these means of payment. In order to keep our fees reduced for families with financial needs, our commitment to patient mental health privacy, and due to philosophy of practice regarding diagnosis of mental disorders, our clinic operates on a **self-pay system**, and our clinicians are **out of network with all insurance companies**, and you may file your receipts (distributed electronically via email) for reimbursement with your insurance carrier if you prefer. If you choose to do this, all of the necessary information is available on your receipt (clinic tax ID number, treatment codes, and address of clinic), but in addition, your clinician will be required to provide a diagnosis code. Please discuss the risk and benefits of receiving a mental health diagnosis with your clinician, as there are several factors to consider.

Self-Pay Ability-To-Pay Scale

We are committed to providing the best care possible to every client, regardless of income level. To increase commitment to treatment, we believe it is beneficial to charge all clients a fee of some amount. Therefore, we use the following sliding scale shown below as a guideline for fee assessment. **Please circle income level and corresponding fee amount. Use this amount for the agreed session fee on Financial Contract.**

Annual Household Income (after tax)	Dependents in Client Household					
	0 (None)	1	2	3	4	5+
\$25,000 -	100.00	100.00	100.00	100.00	100.00	100.00
\$30,000	110.00	100.00	100.00	100.00	100.00	100.00
\$35,000	110.00	110.00	100.00	100.00	100.00	100.00
\$40,000	120.00	110.00	110.00	105.00	100.00	100.00
\$45,000	120.00	120.00	110.00	110.00	100.00	100.00
\$50,000	125.00	120.00	120.00	110.00	105.00	100.00
\$55,000	125.00	125.00	120.00	115.00	105.00	100.00
\$60,000	130.00	125.00	125.00	120.00	110.00	105.00
\$65,000	130.00	130.00	125.00	120.00	110.00	105.00
\$70,000	135.00	130.00	130.00	125.00	120.00	110.00
\$75,000	135.00	135.00	130.00	125.00	120.00	120.00
\$80,000	140.00	135.00	135.00	130.00	125.00	120.00
\$90,000	145.00	140.00	135.00	135.00	130.00	125.00
\$100,000-199,999	150.00	145.00	140.00	140.00	135.00	130.00
\$200,000+	150.00	150.00	150.00	150.00	150.00	150.00

You agree to a fee amount of _____ based on Secure’s Ability-To-Pay Scale (above). Initial/Date Here: _____

When and How To Pay

Payments are expected at the time of service. Secure Counseling Clinic, LLC accepts cash, checks (made payable to “Secure” or “Secure Counseling Clinic” with your counselor’s name in the memo line), and credit cards. There is a \$3.00 per session transaction fee for any electronic (credit or debit) transactions. Many of our clients opt into the automated payment option, through which your session fees will be automatically charged to a credit or debit card that you authorize with this form, should you choose. Payment may run up to 24 hours prior to the start time of the session.

All receipts and invoices are paperless. We require an email address in order to deliver these documents.

To maintain absolute confidentiality for our clients’ therapy records, we do not work directly with third party payment groups; however, we can provide you with receipts for your therapy after you have paid yourself, which you may then submit to your insurance company for partial reimbursement for out-of-network provided treatment (see Insurance Claims above).

Additional Professional Fees:

Extended Phone Consultations:

Your therapist is available for phone consultations outside of session regarding brief administrative, logistical needs. Generally, these conversations last 5-10 minutes and tend to be infrequent. We are happy to discuss scheduling, finances, brief treatment planning on the phone with our clients. If a phone conversation lasts longer than 15 minutes in duration or the nature of the phone call is therapeutic rather than administrative, your clinician may charge a prorated amount of your session fee in increments of 5 minutes (.12 hour).

Office Session Overage:

Sometimes a client needs a little more time before leaving a session because of the intensity of the discussion. We work hard to keep sessions running on time, so that clients can come and depart on time. Occasionally, a session runs slightly over or under one hour - most often these times are not noted because things tend to "all come out in the wash." A standard therapy "hour" in medical billing is 50 minutes. Our sessions generally tend to run between 55-60 minutes because we enjoy spending as much time as we can helping you. If your session runs over the allotted time consistently, your clinician may charge a prorated amount of your session fee for the additional time. For example, if your session fee is \$125/hr, and you are 5 minutes over, you may be charged \$140 (\$15.00 is .12 of an hour).

Court-Related Matters:

Sometimes, correspondence with other agencies (insurance, courts, other professionals, etc.) is required. Most phone contact or brief letters to medical or mental health professionals regarding your case will be a complimentary part of our services; however, any communication, verbal or written that involves the court system, attorneys or litigation will be billed the full private practice fee of \$150/hr (prorated by the .25 hour), not at the agreed session fee. If a counselor of Secure is required to appear for any court related meetings, including depositions or expert witness appearances, you will be billed in full for the preparation time and the amount of time that the counselor is required to block out his or her schedule, regardless of whether the appearance takes place once the cancellation is less than 72 hours (3 days) from the required appearance. For example, if your counselor is subpoenaed as a witness, and s/he is required to block 4 hours of clinical time for the appearance, you will be billed for 4 hours, and 72 hours notice of settlement or cancellation of the appearance is required.

Extended (Cumulative >2 Hours) of Communication with Medical/Social Work/Mental Health Professionals:

Extended letters or contact (cumulative 2+ hours) with other mental health, medical or social work professionals may eventually result in these same prorated charges. In all correspondence, you will need to sign an *Authorization for Release of Information*.

Reading, Correspondence, Emailing for Therapeutic Purposes:

Bibliotherapy, or the use of media (movies or music your request your therapist watch/listen to), books, letter-writing, journaling or emailing, proves an effective form of supplemental treatment alongside regular sessions. Parents often require email correspondence for coaching or consultation in between sessions for minor clients. If you and your therapist discuss the use of this format in between your regular sessions, your therapist will be reading your therapeutic material (books, letter-writing, etc) and this time will be billed at \$60/hour. The fees will be prorated at the .25 hour (for example, if your therapist spends .75 hours (45 minutes) reading through journals you have emailed, you will be billed \$45).

Charge Plan Agreement for 48-Hour Cancellation Policy, No-Show Policy, and Non-Payment at Time of Session

IMPORTANT: REGARDING CANCELLATIONS

Once you have made an appointment with your clinician, the clinician has now reserved the session time *exclusively for you*. We require 48 hours notice of cancellation (which you can do online through our scheduling software anytime of day/night by following the links in your session confirmation email), and preferably, the most notice you are able to provide once you know you will not be able to make a session time. If you are unable to be physically present for the session, your counselor can meet with you through remote connections such as Facetime, Skype, or a telephone-enabled session. For example, in case of inclement weather or you/your child being ill (therefore home from daycare/school/work), your counselor is able to meet with you through technology-enabled means, including the telephone. **If you cancel less than 24 hours from your session time, regardless of the reason, you will be charged the agreed session fee for that time. If you cancel 48 to 24 hours from your session time, you will be charged 50% (half) the amount of your agreed session fee. Our No-Show Policy also states that you will be billed in full for not showing up for your appointment.**

In order to proceed with our financial policies, we require an authorization of a credit or debit card that will be used in the instance that clients choose not to attend a scheduled session. No deposit will be placed on the card, and no charge will be made unless you do not cancel with 48 hours notice, do not show up for your scheduled session, or provide no payment at the time of the session with no

alternative arrangements. If you have enrolled in the Automatic Payment Plan, payments will continue as planned. **With all electronic transactions, there is a \$3.00 per session hour fee.**

Your clinician values the exclusivity of your scheduled sessions and schedules a period of time to give your his or her undivided attention. Thank you for understanding and agreeing to our policies and for respecting your clinician's time.

If you choose not to agree to authorize a credit or debit card charge in the event that you cancel with less than 48 hours or do not show up for your session, you will be required to place a cash or check deposit (in addition to today's session fee). This deposit will be used in the instance of less than 48 hours cancellation, non-payment at time of session, or your not showing up for your scheduled appointment. When this happens, you will be required to place a new deposit, to be held in the same manner.

1. CANCELLATION PAYMENT AGREEMENT

This is required to help you avoid the build up of unpaid balances with our practice. In the event that I cancel with less than 48 hours notice or do not show up for a scheduled session, I authorize my credit or debit card payment. I understand and have agreed to the 48-Hour Cancellation Policy, No-Show Policy, and Non-Payment at the Time of Session Charge Plan. Unless other payment arrangements are discussed, non-payment at the time of session may result billing the credit card on file (provided for less than 48 hours cancellation notice). Non-payment may result in termination of services.

2. SESSION PAYMENT

Secure Counseling Clinic offers an automatic credit card payment system for your convenience, so that you do not have to remember payment at the time of your session and may focus on therapy instead. I authorize automatic payment charges made to my credit card online by Secure Counseling Clinic, LLC. I understand that the online processing of my credit card is private, secure and compliant with HIPAA regulations. I understand that there is a \$3.00 per session electronic transaction fee (for both credit and debit cards). I also understand that I may opt out of this plan at any time or provide another form of payment at the time of my session, and that I must submit a request in writing and fill out a new Financial Contract if I would like to opt out of the automatic payment option. By my signature below, I am opting into the automatic debit or credit card payment option. The credit card listed BELOW will be charged. No charges will be made if payment is provided with cash or check.

Credit or Debit Card Information (choose one):

Please use the card provided when my appointment was scheduled.

OR

Please use this card instead:

Name on Card: _____

Visa Mastercard American Express Discover

Card Number: _____

Exp. Date: _____ Validation Code: _____

Billing Address: _____

****All hardcopy credit card information is kept as HIPAA protected information behind multiple locks.**

3. I have been fully informed about all financial matters regarding my treatment (p.11-13). I understand and agree to the financial policies of Secure.

Client Signature: _____ Date: _____



Technology-Enabled Counseling Policies

TECHNOLOGY-ENABLED COUNSELING (Sessions on Zoom, Skype, FaceTime, Phone)

Your counselor abides by the ethical code enforced by the American Counseling Association, most specifically those associated with online counseling and technology in Section A.12. Technology Applications of the ACA Code of Ethics. Currently, counseling laws state that you must have a residential address in the state where your counselor is licensed in order to participate in ongoing technology-enabled counseling (without face-to-face meetings). If a face-to-face, in office counseling relationship is already established for a MO resident, technology enabled sessions are within the boundaries of normal treatment. Our counselors are licensed in the State of Kansas. We may counsel exclusively by technology (phone, video chat) anyone who also resides in Kansas, whether locally or several hours away. Please be aware that Skype is not encrypted, while FaceTime is encrypted. We also have access to Zoom, a HIPPA compliant conferencing app, should you want to use that platform yourself. The intake process, billing, paperwork and policies are all the same as a face-to-face client. We do not have a landline as a clinic, as we choose to use cell phone communication to maximize our availability to you. Your counselor also reserves the right to refuse technology-enabled counseling based on best clinical judgement related to your physical safety and therapy needs.

FAX, TELEPHONE, EMAIL COMMUNICATION

Cell phone communication, fax, email, and texting are not confidential forms of communication, and the choice to use them to communicate with your counselor is assumed when you provide your contact information at intake. Our counselors use cell phones for communications in the interest of being responsive and available to you as a client. You are responsible for ensuring the confidentiality of the location in which you schedule your appointments online, speak on the phone, email, or text (for example, emailing on a computer at work or a public library is not as confidential as emailing at home). We do not utilize a landline telephone or fax machine, so that paperwork is not visible to anyone who might enter our offices. The only guaranteed confidential form of communication available is face-to-face communication. If you choose to fax content to us, our fax number is 1-866-755-4670. Fax is not confidential - by choosing to fax, you waive the confidentiality risk.

SOCIAL MEDIA POLICY (Facebook, MySpace, Linked In, etc.)

Social Media consists of such networking platforms online as Facebook, MySpace, Linked In, etc. In order to protect the privacy of our clients and to contain the exclusivity of counseling to the counseling room, we do not form connections on these platforms. If connections already exist at the time of intake, clinicians will use discretion about whether or not to maintain the connection, based on what is in the best interests of each client. Our clinic does have a Facebook Page; if you become a Fan or "Like" our clinic, you may become visibly associated with our clinic to others on Facebook. We leave "like" and becoming a fan to the choice of our clients; please be aware that your confidentiality as a possible client of our clinic may become known. This is your decision.

AGREEMENT

I understand that counseling sessions on the phone and online are billable and are subject to all of the same policies and procedures of Secure Counseling Clinic, LLC as regular sessions in the clinic.

I understand that all legal, ethical, and therapeutic contracts signed at my intake with Secure Counseling Clinic, LLC are still intact and apply to the online, telephone or other chat venue, such as FaceTime (encrypted) or Skype (not encrypted), used for my counseling session. My counselor abides by the ethical code enforced by the American Counseling Association, most specifically those associated with online counseling and technology in Section A.12. Technology Applications of the ACA Code of Ethics. I have considered, understand, and agree to the risks, benefits, and alternatives to the use of chat and/or email and other forms of online communication in clinical work with my counselor. I understand that every effort will be made to maintain the confidentiality of our communications, including but not limited to provision of secure chat room and secure storage of any electronic file communication according to ACA professional standards. I understand that no communication on the Internet can be guaranteed completely free from potential breach of confidentiality in transit by hackers or Internet service providers or by others who had access to the account or the computer. I TAKE FULL RESPONSIBILITY FOR THE CONFIDENTIALITY AND SECURITY OF COUNSELING AND COMMUNICATION RECEIVED AT MY OWN PHYSICAL LOCATION. My counselor will not be held liable for any breach of confidentiality that takes place on my end. I understand that my counselor uses a cell phone primarily for business and that my information is kept as secure as possible, however I also understand that cell phone communication is never completely confidential. I also understand that email, fax, texting, and other electronic forms of communication are not entirely confidential, should I choose to use them to communicate with my counselor. I have been informed of circumstances in which online counseling or therapy is not the appropriate or most effective treatment. In the event of a medical, psychiatric, or other situation requiring face to face intervention, I understand that it is my responsibility to seek such help. IF I AM CURRENTLY CONSIDERING OR THREATENING SUICIDE OR ANY FORM OF HARM TO MYSELF OR OTHERS, I TAKE FULL RESPONSIBILITY FOR SEEKING APPROPRIATE HELP IN MY AREA IMMEDIATELY. I also understand that my counselor will assist me in ensuring that I have local resources to access should an emergency occur prior to engaging in online counseling.

I understand I have a right not to sign this form, however doing so would make me ineligible to receive services from my counselor through an online medium. By signing below, I consent to enter into a counseling session online, by telephone or other technology.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

Minor Consent Form

DATE: _____

This is to certify that I/we, _____, have legal custody or guardianship of the following child(ren) and have the legal right to authorize the care, treatment, and counsel of this/these child(ren):

Name of Child	Date of Birth

I give consent for him/her/them to receive services from this counselor.

I further consent, in the interest of maximizing the effectiveness of the services provided, that the content of this counseling, with the exception of the content of any given sessions where I may be invited to be present, will be considered confidential and will not be divulged to me without my child’s knowledge. I understand that if my child is in danger of harm or harming others, if a court subpoenas my child’s therapy records or counselor appearance, my counselor is legally mandated to report possible harm to appropriate authorities, as well as make mandated appearances.

As the parent/guardian, I agree to participate in the above child(ren)’s therapy treatment by possibly attending parent sessions, classes, and/or implementing interventions at home that my counselor recommends. I understand that my child(ren)’s therapy progress does heavily rely on my ability to follow treatment recommendations on the child’s behalf.

(Required) Legal Custodial Parent/Guardian Signature _____ Date _____

Legal Custodial Parent/Guardian Signature _____ Date _____

Image and Writing Release Form (OPTIONAL)

I agree to allow Secure Counseling Clinic, LLC to display the following items of myself or my minor child (ren) for the purpose of affirming my therapy growth and sharing the message or artistic expression of my emotions with others. I understand that my name will be withheld in any display of artwork, writing, or photographs.

Initial all that apply:

_____ Paintings, drawings, 3D models or clay, photos of sand tray activities, etc.

_____ Photographs of me or my family doing activities at Secure events (no video recordings of sessions are ever shared in this capacity) OR Photos I provide to my counselor (such as Christmas cards, school photos)

_____ Essays, poetry, or other forms of writing expression

_____ Other (please specify) _____

By my signature below, I am giving permission for the staff of Secure to display the above named items.

(Required) Legal Custodial Parent/Guardian Signature _____ Date _____

Legal Custodial Parent/Guardian Signature _____ Date _____

PLEASE READ AND INITIAL BY EACH ITEM BELOW, PAGES 17-23.

You will be provided a copy of these policies for your records at your first session, and this blank document is available for you to download on our website at any time.

Treatment Guide

BENEFITS AND RISKS OF THERAPY:

Any time you seek therapy to work with the difficulties in yourself or your relationships there are benefits and risks involved. The **benefits** can include the ability to handle or cope with your specific concerns and/or your interpersonal relationships in a healthier way. You may also gain a great understanding of personal, interpersonal, or family goals and values. This new understanding may lead to greater maturity and happiness as an individual, couple, or as a family. There may also be other benefits that come as you work at resolving your specific concerns. However, therapy can be **challenging and uncomfortable at times** and there are no guarantees to the outcome you desire. Remembering and resolving an unpleasant event may cause intense feelings of fear, anger, depression and frustration. As you work to resolve personal issues or issues between family members, marital partners, and other persons, you may experience discomfort and an increase in conflict. There may be changes in your relationships, which you had not originally intended. Your counselor will discuss with you the benefits and risks involved in your particular situation.

THERAPEUTIC APPROACH:

At Secure, we focus on the *neurobiology of human behavior and relationships*. Treatment at Secure Counseling Clinic is based on an **emotion-focused approach**, which is a combination of *biological attachment theory and family systems theory*. Our therapeutic approach at Secure is well-rounded, as we take all aspects of a client into consideration. In your treatment, we will look at the entire system you are a part of: *your family, personality, work, religion and spirituality, your thoughts/cognitions, society, innate heretical factors, medical conditions, etc.* Practitioners at Secure conceptualize presenting concerns from an attachment-based perspective: human behavior and emotions stem from the innate need to belong, to be accepted, to be comforted, and to be protected from harm. Our practitioners believe that the need to attach to the people we love in a healthy way is consistent across the life cycle - from the cradle to the grave.

TREATMENT OF CHILDREN AND ADOLESCENTS

Secure Counseling Clinic, LLC provides clinical outpatient counseling services. As a part of treatment, recommendations regarding family system issues and/or other psychosocial matters which are impacting the child may occur. Consideration of these recommendations are a vital part of the therapy process. Failure to consider clinical recommendations and implement therapeutic changes on the part of parents/guardians or other adults in your child's psychosocial environments may create substantial obstacles to your child's treatment and limit his/her ability to benefit from the outpatient counseling provided. As the parent/guardian, you agree to participate in child(ren)'s therapy treatment by possibly attending parent sessions, classes, and/or implementing interventions at home that your counselor recommends. Child(ren)'s therapy progress does heavily rely on parental ability to follow treatment recommendations on the child's behalf. These services are intended to address your child's treatment and clinical needs and are not intended to serve in any other manner, including those described below.

- Secure's services do not include formal placement or formal custody evaluation.
- Secure's services do not include conducting a home study.
- Secure's services are not forensic in nature and do not include determining if something has or has not happened to a child.

ALTERNATIVE APPROACHES:

If you would like **referrals** to other agencies or practitioners with alternative approaches to counseling, other options are available; for example, cognitive-behavioral therapy, psychodynamic therapy, self-help groups or anonymous support groups, or medications prescribed by a physician or psychiatrist. Your counselor or a member of the Secure staff can provide you with more information about other forms of treatment that might be right for you. Your clinician will likely recommend additional interventions to meet your needs. Some possible referrals may include medical doctors, psychiatric consultation, occupational therapy, other forms of mental health treatment, supplemental groups or classes, massage or natural forms of intervention (nutritionist, dietician, etc).

Privacy Practices

CONFIDENTIALITY:

The information you provide in therapy is confidential. Your therapist will not reveal any information about you or your issues, except for professional consultation, without your written consent. Your therapist will not reveal that you are a client at Secure Counseling Clinic or initiate contact/acknowledge that s/he knows you if you were to meet outside of the clinic location, in order to protect your right to privacy. You may always initiate or acknowledge contact outside of the therapy location yourself. Any written records of your treatment are also confidential. **Because of our legal mandate to report some issues, confidentiality may be broken if you are found to be a clear or imminent danger to yourself or others, if you report current abuse of a child or dependent adult, or if a judge court orders your records.**

CONFIDENTIALITY IN PUBLIC SETTING:

If you encounter your counselor in a public setting (grocery stores, community events, school, etc.), s/he will NOT acknowledge any relationship with you in the interests of protecting your privacy. You are welcome to approach or acknowledge your relationship, but it must be initiated by you.

MINOR CONFIDENTIALITY POLICY:

In the state of Kansas, parents are allowed access to information about their children in therapy. If we are treating a **minor child individually**, our Minor Consent Form has a statement about the content of these sessions being confidential, even from parents, in the interests of maximizing the effectiveness of therapy in a private/individual session. This is common professional practice in counseling treatment of children and adolescents. If there are life-threatening concerns, the same policy of breaking confidentiality (emphasized above) applies.

“NO SECRETS” POLICY

During the course of our work with a couple or a family, we may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that we are doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions, please understand that generally these sessions are confidential in accordance with our Confidentiality Policy. However, we may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if we are to effectively serve the unit being treated. Your counselor will use his/her best judgment as to whether, when, and to what extent disclosures are made to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually. The “No Secrets” Policy is intended to allow us to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. This policy is intended to prevent the need for termination of therapy because of a conflict of interests between individual members and the family.

ART AND IMAGE CONFIDENTIALITY POLICY

We never hang or display any art or photographs of clients’ unless we have written consent to do so. If you and your counselor will be **hanging your artwork in one of our therapy rooms**, you will need to sign our Art and Image Consent form to allow items to be displayed for the purpose of affirming your therapy growth and sharing the message or artistic expression of your emotions with others. Your name(s) will be withheld in any display of artwork, writing, or photographs.

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_____ **RECORD KEEPING POLICY**

A file is kept for each case seen, which includes an your Client Information Packet, Informed Consent Form, any Authorizations for Release of Information, financial record keeping, progress notes, and any other correspondence or information related to that case. Records are stored in a locked, secure cabinet in a locked closet for confidentiality purposes and will be held for at least **seven years after termination**, or the end of therapy. If **client is a minor**, his/her records will be kept for seven years after termination or after 18 years of age, whichever comes chronologically later.

_____ **CONSULTATION WITH OTHER PROFESSIONALS ASIDE FROM SUPERVISOR/PEER SUPERVISEES**

If client records need to be seen by another professional or anyone else, counselor will discuss it with client. If client agrees to share these records, an **Authorization for Release of Information form** will be completed. This form states what information is to be shared, with whom, why, and for how long the information may be shared. Your counselor has reached the highest level of licensure available for practicing clinicians (LCPC), therefore are not required to be supervised. Because we believe that the integrity of our professional training requires the occasional consultation with other clinicians, we ask your permission to disclose information about your case to the below listed professionals. Secure Counseling Clinic and its counselors believe that these practices also contribute to the high quality of professional services provided for you, our valued client. All identifying information about you and your family is kept confidential, and your counselor reveals only relevant case information for discussion of best practice and appropriate treatment. The therapy offered to you is delivered by a Licensed Clinical Professional Counselor in the State of Kansas. Vanessa Knight, LCPC (#2330), NCC (#270119), CCMHC and Ben Taussig, LCPC (#2344), NCC (#270122). Both Ben Taussig and Vanessa Knight consult with

one another regarding Secure Clinic cases, as practicing partners. Both partners occasionally participate in collegial consultation groups with other private practice clinicians for the purpose of continuing education and the pursuit of professional excellence.

PRACTICE WILL

Should either counselor of Secure become unavailable, incapacitated, or deceased, the co-owner and partner of that counselor will assume responsibility for your case, files, treatment and referrals to additional/alternative professionals. Your file will be maintained by Secure for a total of seven (7) years after the final date of treatment. Minor files are maintained for 7 years after the child's 18th birthday or the final date of treatment, whichever is later.

AUDIO or VIDEO RECORDING OF SESSIONS (Optional Consent)

You may have given optional permission to allow your counselor to make audio or video recordings of counseling sessions for your counselor to replay session interactions in order to further help you/your family or for consultation/training purposes (portions of these recordings may be reviewed by the counselor's consultants/supervisor(s) as part of his or her professional continuing education or certification requirements). **All recordings are destroyed following viewing and are not kept as a part of formal client files at any time.** All recordings are treated with the same ethical concern as confidential records. If you gave your optional consent, your counselor may present the case and segments of audio or video during group consultation/supervision for the purpose of excellence in case management and training.

PHONE CONTACT AND EMERGENCY POLICY

You may contact our office by dialing 913-735-3384 (general voicemail). Ben Taussig may be reached at 913-735-5128; Vanessa Knight may be reached at 913-735-4899. We are not available for 24-hour emergency care. A client cannot assume that we will be available at all times. In case of an emergency and the inability to reach us, immediate contact should be made to one of the following crisis hotlines:

Emergencies: 911

Battered Person's 24 Hour Hotline: 816-995-1000

Child Abuse (KS): 1-800-922-5330

Child Abuse (MO): 1-800-392-3738

Johnson County Mental Health: 913-782-2100

Rape Crisis Line (KS): 913-642-0233

Rape Crisis Line (MO): 816-531-0233

Suicide Prevention Line: 1-800-273-8255

Attendance and Billing Policies

LENGTH AND ATTENDANCE OF SCHEDULED SERVICES:

A regular therapy session is 50 minutes in length in order to allow adequate preparation for your session and processing of your paperwork at the beginning and end of your session. **Session lengths may be extended with prior discussion** between client and counselor when deemed necessary for meeting treatment goals. Attendance at scheduled therapy sessions is expected.

48 HOUR CANCELLATION NOTICE:

Once you have made an appointment with your clinician, the clinician has now reserved the session time **exclusively for you**. We require 48 hours notice of cancellation (which you can do online through our scheduling software anytime of day/night by following the links in your session confirmation email), and preferably, the most notice you are able to provide once you know you will not be able to make a session time. If you are unable to be physically present for the session, your counselor can meet with you through remote connections such as Facetime, Skype, or a telephone-enabled session. For example, in case of inclement weather or you/your child being ill (therefore home from daycare/school/work), your counselor may be able to meet with you through technology-enabled means, including the telephone. Negative emotion due to being billed for sessions cancelled within the 48 hour window tends to be one of the common reasons for discontinuation of therapy - in order to avoid this trap, please be sure that you understand and joyfully agree to pay your therapist for the time exclusively and respectfully reserved for you in his/her schedule. **If you cancel less than 24 hours from your session time, regardless of the reason, you will be charged the agreed session fee for that time. If you cancel 48 to 24 hours from your session time, you will be charged 50% (half) the amount of your agreed session fee. Our No-Show Policy also states that you will be billed in full for not showing up for your appointment.** A cancellation must be made with **48 hours notice in order to avoid being billed/charged the full amount due for the session.** Please call your counselor's direct phone extension (not the general voicemail line or by email) to advise of cancellations as soon as you are aware that you cannot make your scheduled appointment in order to allow the spot to be filled. Your appointment reminder email from Genbook is a *no reply* email address - if you attempt to cancel by replying to that address, you will be billed. **Excessive cancellations** may result in a discussion of readiness or motivation for therapy and may result in services being placed on hold status at that time. Services may be reinstated at a later date, subject to discussion with counselor, and the intake process must be repeated.

"NO-SHOWS":

A no-show occurs when a client does not call ahead of time to cancel an appointment and does not attend a scheduled session. Cancellation with less than 24 hours notice will be considered a no-show, and the client will be **billed/charged the full amount for the missed session**. A total of **three (3) no-shows** will result in termination of services. Services may be reinstated at a later date; however, the intake process must be repeated.

LATE ARRIVAL FOR SESSIONS:

If a client arrives for a therapy session fifteen (15) minutes late or later, therapy cannot take place due to lack of sufficient time for the session, and **the client will be billed/charged the full amount for the session**. If the counselor is running behind in the day's schedule, s/he will do his/her best to allow your full allotted time or the time will be made up to you.

INACTIVE STATUS AND RE-INTAKE

Your client file will become inactive after sixty (60) days of non-attendance at the clinic. You can begin counseling again at any time. You will complete a Reintake Form to update your *contact information*, alert your counselor to any *life changes*, and reevaluate your Financial Contract.

WINTER WEATHER:

In the event of **severe winter weather**, your counselor will be in touch with you as soon as possible regarding the status of your appointment. In most instances, your counselor will be available for technology-enabled sessions (Facetime, Skype or telephone). If you plan to cancel due to driving conditions, please call your counselor's direct phone extension as soon as you have made your

decision. Winter weather will be considered on a case by case basis; however, the default policy for cancellation is our 48-Hour Cancellation Policy (see above).

FEES:

We are committed to providing the best care possible to every client, regardless of income level. To increase commitment to treatment, we believe it is beneficial to charge all clients a fee of some amount. Therefore, we use the following sliding scale shown below as a guideline for fee assessment. ***Please circle income level and corresponding fee amount. Use this amount for the agreed session fee on Financial Contract.*** Counseling services are offered on an ability-to-pay scale of \$100-150, depending on your annual household income and the number of dependents living in your household. **Payments are expected at the time of service. Secure Counseling Clinic, LLC accepts cash, checks (made payable to “Secure” or “Secure Counseling Clinic, LLC”), and credit cards. For all credit card transactions, a flat processing fee of \$3.00 per one-hour session will be charged (e.g. if you attend a two-hour session, a \$6 fee would be assessed).** The self-pay fee chart is available on page 12 of this packet.

DEPOSIT AND/OR CHARGE PLAN AGREEMENT

Once you have made an appointment with your clinician, the clinician has now reserved the session time exclusively for you. We require a minimum of 48 hours notice of cancellation, and preferably the most notice you are able to provide once you know you will not be able to make a session time. Our No-Show Policy also states that you will be billed in full for not showing up for your appointment. In order to proceed with our financial policies, we require an authorization of a credit or debit card that will be used in the instance that clients choose not to attend a scheduled session. No deposit will be placed on the card, and no charge will be made unless you do not cancel with 48 hours notice or do not show up for your scheduled session. If you have enrolled in the Automatic Payment Plan, payments will continue as planned. Your clinician values the exclusivity of your scheduled sessions and schedules a period of time to give your his or her undivided attention. Thank you for understanding and agreeing to our policies. If you choose not to agree to authorize a credit or debit card charge, you will be required to place a cash or check deposit (in addition to today’s session fee). This deposit will be used in the instance of less than 48 hours cancellation or your not showing up for your scheduled appointment. When this happens, you will be required to place another deposit, to be held in the same manner.

WORKING WITH INSURANCE COMPANIES

In order to keep our fees reduced for families with financial needs, our commitment to patient mental health privacy, and due to philosophy of practice regarding diagnosis of mental disorders, our clinic operates on a self-pay system, and our clinicians are out of network with all insurance companies, and you may file your receipts (distributed electronically via email) for reimbursement with your insurance carrier if you prefer. If you choose to do this, all of the necessary information is available on your receipt (clinic tax ID number, treatment codes, and address of clinic), but in addition, your clinician will be required to provide a diagnosis code. Please discuss the risk and benefits of receiving a mental health diagnosis with your clinician, as there are several factors to consider. If you have a Health Savings Account or a flexible benefits account, receipts are generally 100% reimbursable through these means of payment.

ADDITIONAL FEES FOR EXTENDED ADMINISTRATIVE OR CONSULTATION TIME

Sometimes, correspondence with other mental health or medical agencies is required and most phone contact or brief letters to your case will be a complimentary part of our services.

Extended Phone Consultations:

Your therapist is available for phone consultations outside of session regarding brief administrative, logistical needs. Generally, these conversations last 5-10 minutes and tend to be infrequent. We are happy to discuss scheduling, finances, brief treatment planning on the phone with our clients. If a phone conversation lasts longer than 15 minutes in duration or the nature of the phone call is therapeutic rather than administrative, your clinician may charge a prorated amount of your session fee in increments of 5 minutes (.12 hour).

Office Session Overage:

Sometimes a client needs a little more time before leaving a session because of the intensity of the discussion. We work hard to keep sessions running on time, so that clients can come and depart on time. Occasionally, a session runs slightly over or under one hour - most often these times are not noted because things tend to "all come out in the wash." A standard therapy "hour" in medical billing is 50 minutes. Our sessions generally tend to run between 55-60 minutes because we enjoy spending as much time as we can helping you. If your session runs over the allotted time consistently, your clinician may charge a prorated amount of your session fee for the additional time. For example, if your session fee is \$125/hr, and you are 5 minutes over, you may be charged \$140 (\$15.00 is .12 of an hour).

Court-Related Matters:

Sometimes, correspondence with other agencies (insurance, courts, other professionals, etc.) is required. Most phone contact or brief letters to medical or mental health professionals regarding your case will be a complimentary part of our services; however, any communication, verbal or written that involves the court system, attorneys or litigation will be billed the full private practice fee of \$125/hr (prorated by the .25 hour), not at the agreed session fee. If a counselor of Secure is required to appear for any court related meetings, including depositions or expert witness appearances, you will be billed in full for the preparation time and the amount of time that the counselor is required to block out his or her schedule, regardless of whether the appearance takes place once the cancellation is less than 72 hours (3 days) from the required appearance. For example, if your counselor is subpoenaed as a witness, and s/he is required to block 4 hours of clinical time for the appearance, you will be billed for 4 hours, and 72 hours notice of settlement or cancellation of the appearance is required.

Extended (Cumulative >2 Hours) of Communication with Medical/Social Work/Mental Health Professionals:

Extended letters or contact (cumulative 2+ hours) with other mental health, medical or social work professionals may eventually result in these same prorated charges. In all correspondence, you will need to sign an *Authorization for Release of Information*.

Reading, Correspondence, Emailing for Therapeutic Purposes:

Bibliotherapy, or the use of media (movies or music you request your therapist watch/listen to), books, letter-writing, journaling or emailing, proves an effective form of supplemental treatment alongside regular sessions. Parents often require email correspondence for coaching or consultation in between sessions for minor clients. If you and your therapist discuss the use of this format in between your regular sessions, your therapist will be reading your therapeutic material (books, letter-writing, etc) and this time will be billed at \$60/hour. The fees will be prorated at the .25 hour (for example, if your therapist spends .75 hours (45 minutes) reading through journals you have emailed, you will be billed \$45).

PAYMENT:

Payment for each session is due at the beginning of appointment time. The amount of each clients payment is determined Intake Administration (first session). A Financial Contract is signed by both the client and counselor. Non-payment at the time of session may result in the credit card on file being charged or loss of deposit. Continued non-payment will result in termination of services.

LATE PAYMENT FEE

If your account carries a balance for an extended period of time, you will be charged a late fee of \$15/month for every month there is an existing balance on your account that is more than three months old. We help you avoid late payment fees altogether by collect credit card information for our Deposit And/Or Charge Plan Agreement (see above).

PRO-BONO CLIENTS POLICY

Each counselor, at his/her **discretion**, may choose to serve a client at a pro bono fee (lower than \$100 per session) as a contribution for the general good. Each counselor may make individualized arrangements with these clients on a case-by-case basis. Most of the time, even pro-bono clients are required to pay a minimal amount for therapy services as a part of maintaining the value and commitment to therapy itself by the individual/family.