Counseling Associates of the Four States, LLC
705 W. 26th Joplin, Mo 64804
417-627-9994

Registration Form: **DATE:**

Please fill this information out for the person being seen as the CLIENT today.

CLIENT INFORMATION:

Client name_____ Age_____
Birth Date_____ Social Security # _____
Marital Status: *(circle)* M D S W Gender: Male/ Female
Address _____
City_____State_____Zip _____
Home Phone _____ Call Y/N Voicemail Y/N
Cell Phone_____ Call Y/N Voicemail Y/N
Email _____ Ok to Email? Y/N

Appointment Reminders are done via text message if you are unable to receive text's please inform us at the window. Thank you!

Place of Employment: *(Insurance Purpose)*

_____
Work Phone_____ OK TO CALL? YES / NO

How did you hear about us? Website Facebook Friend Other_____

Please fill this portion out if the above client is a minor or there is another responsible billing party.

SPOUSE/ PARENT or GUARDIAN INFORMATION:

Name _____ Age _____
Birth Date_____ Social Security #_____
Marital Status*(circle)* M S D W Gender: Male/ Female
Relationship to Client:_____
Address _____
City_____ State _____Zip _____
Home Phone _____ Call Y/N Voicemail Y/N
Cell Phone _____ Call Y/N Voicemail Y/N
Email _____ Ok to Email? Y/N

Appointment Reminders are done via text message if you are unable to receive text's please inform us at the window. Thank you!

Place of Employment: *(Insurance Purpose)*

_____
Work phone _____ OK TO CALL? YES/NO

Other Parent Info:

Name: _____ Phone:_____
Place Of Employment: _____

Counseling Associates of the Four States, LLC
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Informed Consent for Counseling Services

Risks and Benefits of Therapy: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will expect you to respond openly and honestly. During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed.

Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and their assessment of what will best benefit you. Their approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, development, or psycho-educational techniques.

Discussion of Treatment Plans: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives and their view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. **You also have the right to refuse to participate in a treatment plan or ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, your therapist has an ethical obligation to assist you in obtaining these treatments.**

Cancelled, Missed, and Late Appointment Policy: Counseling Associates is committed to providing all of our clients with exceptional care. When a client cancels without giving enough notice, they prevent another client from being seen at this time. Please call or text 24 hours prior to your scheduled appointment to notify us if you're unable to keep the appointment. For Monday appointments, please call our office by 2 pm on the Friday before If prior notification is not given, you will be charged a minimum of $25 for a late cancellation and $75 for a no show appointment. If you LC or NS three or more scheduled appointments, there's a potential that you won't be able to reschedule. Please be advised that your counselor is typically scheduled every hour. If you are more than 15 minutes late for your scheduled time it may not be possible for you to be seen that day.

Delinquent Accounts: You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay the actual balance due plus any collection expenses incurred to collect that balance. Extra fees will include a $5.00 statement fee per billing cycle for balances left unpaid over 30 days, any attorney fees associated with the collection of delinquent accounts and any court fees.

Insurance: Except for Medicaid and Managed Care Programs, you are responsible for obtaining any necessary prior authorization for treatment from your insurance carrier. By prior arrangement and as a courtesy, Counseling Associates is happy to bill your insurance for mental health services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan and date of service. Benefits are determined once a claim has been processed and we receive the explanation of benefits (EOB). You are responsible the cost of counseling sessions, regardless of insurance coverage or lack thereof. At any time during treatment should you become ineligible for insurance coverage, you will notify the Billing Assistant and understand you will become responsible for 100% of the bill. In the case that your insurance is no longer in active, all clients are eligible to continue therapy at our self-pay rate of $100 per session.

I, _____, have chosen to allow Counseling Associates of the Four States, to file my insurance and accept full responsibility for this account and for all expenses associated with mental health treatment in this office. I understand it is my responsibility to be aware of what type of mental health insurance plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only a estimate of benefits. I authorize direct payment and grant permission to collect all benefits applicable to my treatment to Counseling Associates of the Four States, LLC.

Court Related Services: If your counselor is served a summons to appear in court on your behalf or that of your minor child, you will be responsible for compensating your counselor for their time required to prepare, travel and time spent in court. This includes time waiting to be called into court. You are not paying for testimony. The rate for court services is $500 for preparation time and $150.00 per hour of court appearance with a minimum of one hour. Additional fees may be incurred as necessary. In lieu of attending court, if your counselor is asked to provide written summary of progress notes or phone consolation with your attorney, you will be charged a minimum of $150. If only copies of records are requested and NO APPEARANCE, there will be a flat fee of $25.00 plus $0.59 per page plus postage if necessary. Any charges related to court are due prior to your court date.

Agreement for Counseling Services: Because therapy often begins in a situation of considerable emotional difficulty, your therapist has an ethical obligation to assist you in obtaining these treatments.

- **Terminating Treatment**: You always have the option to terminate treatment at any time, for any reason. It is customary to discuss this with your therapist in session, so that any concerns either you or your therapist have may be adequately addressed. If your therapist feels that therapy is not benefiting you, your therapist will also discuss this with you.
- **Telephone and Emergency Procedures**: If you need to contact your therapist between sessions, please leave a message with the office staff and your call will be returned as quickly as possible. If an emergency arises, please report to your local hospital emergency room or call local law enforcement. If you need to talk to someone right away, or if there is a life-threatening emergency, please call 911. You can also contact the following 24/7 services.
    - **Ozark Center Crisis Intervention: 417-347-7720 or 800-247-0661**
      For messaging service, text REGISTER to 720-7-TXTOZK (720-789-8695).
    - **National Suicide Prevention Hotline: 800-273-8255**
      For messaging service, text HOME to 741-741.

- Counseling Associates of the Four States, LLC would like your permission to allow another licensed professional, provisionally licensed professional, or intern to attend sessions as an observer and/or co-counselor. This will also be used in order to teach techniques used during sessions. The information will be kept confidential and will only be used as a training tool. All observations/co-counselors are mental health /medical providers. This practice will only be done with your written permission and only in the capacity addressed. If you have any questions regarding this authorization, please ask. This is strictly voluntary and may be revoked at any time.

  _____ I DO agree to allow an observer/co-counselor to attend sessions

  _____ I DO NOT agree to allow an observer/co-counselor to attend sessions

Your Rights and Responsibilities:

You have the right to:

- Be treated with respect and dignity by CAFS personnel.
- Privacy and confidentiality for treatments, tests and procedures you receive.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your treatment plan or the care provided to you.
- Receive timely responses to your concerns.

  It is highly encouraged that you follow the procedure below to address any concerns you may have:

  1. Discuss concerns with your counselor
  2. If your concerns are not answered adequately, speak with CAFS office manager by phone, email, or appointment.
  3. If these options fail to address your concerns, feel free to contact a Patient Advocate at the Missouri Department of Mental Health's Joplin Satellite office at 417-629-3266

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate counselor when you have a concern.
- Show your health plan ID card before receiving services.
- Keep scheduled appointments and pay any necessary co-payment at the time you receive treatment.
- Provide information needed for your care.
- Follow an agreed-upon treatment plans of the counselors.
- Participate in understanding and developing mutually agreed-upon treatment goals.
- Notify CAFS office staff of any changes in your address, family status, or insurance coverage.
- Contact the CAFS office when you have a question about your eligibility, benefits, claims and more.
- Verify a counselor's network participation and your insurance benefits for in-office counseling services prior to receiving services.

Treatment of minors: If parents are divorced or separated, we need to have the appropriate court documents in the child's records showing who has custody and who is responsible for seeking medical care/counseling if it is so indicated in the court document. _This office does not get involved in parental financial disputes. The person signing for the responsibility of the child will be indicated as the one financially responsible for services rendered by our counselors. Any financial arrangements made between divorced/separated parents are to be handled between the parents. CAFS will communicate appointment reminders only to the signed responsible parent/guardian. If anyone other than a parent/legal guardian will be providing transportation for or attending a session with a minor client, CAFS must be notified and the signed responsible parent/guardian must complete an authorization form. CAFS will not be responsible for the safety of minors left unattended in the lobby. It is the signed parent/legal guardian's responsibility to supervise the care of young clients or any children on CAFS property before, during and after appointments.

Counseling Associates of the Four States, LLC strives to ensure that no one is discriminated against in the delivery of mental health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

These notes have been prepared so that you will have an understanding of our basic agreement.
Counseling Associates of the Four States, LLC is owned by Deanna Street, MA, LPC. Each affiliate/therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from his or her practice.

I, (Client/Parent/Guardian), have read and understand the above statements and agree that this is for the best interest of the Client.
I, (Client/Parent/Guardian), agree to the terms, conditions, procedures, and responsibilities described above.

_____ _____
Adult Client – Print Name Date

_____
Adult Client – Signature

_____ _____
Parent/Legal Guardian – Print Name Date

_____ _____
Parent/Legal Guardian – Signature Relationship to Client

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HIPAA Privacy Notice

Client Name: _____ **Date:** _____

As a person receiving services from **COUNSELING ASSOCIATES OF THE FOUR STATES, LLC** you have rights concerning the protected health information that is collected and used to provide these services.

Clients Rights

You must give your permission for certain people outside of the above named agency to see your health information.

- You make revoke this permission by filing a written form.
- When children are in the Children's Division custody, Children's Division staff has the same authority as parents with regard to disclosure of health information.

You can request to see or copy your health information.

- You may be denied access to certain parts of your health information.
- You may appeal to the above named agency's Privacy Officer if access to parts of your health information is denied.

You can request that changes be made in your health information.

- The request may be made to the above named agency's Privacy Officer.
- The request may be either granted OR denied.

You can request that certain parts of your health information not be shared with others.

- The request may be made to the above named agency's Privacy Officer.
- The request may be either granted OR denied.

The above named agency must let you know when the above named agency shares your health information with others

You may contact the above named agency's Privacy Officer at above address/phone number

The Above Named Agency Does NOT Need Authorization when:

The above named agency does NOT need authorization to share your health information with others:

- To make Child Abuse/neglect reports, and to respond to requests concerning child abuse/neglect investigations
- When a Court Orders the above named agency to share your health information.
- To make your health information available to Judicial or Administrative proceedings under certain circumstances.
- If police need certain information from your health information available.
- To help keep someone else safe.

Complaints

If you believe that the above named agency and/or its representatives have improperly used or disclosed your Private Health Information, or that the above named agency is not complying with the requirements of HIPAA, you may file a complaint with one or both of the following:

- Missouri Department of Social Services Complaint Officer, P. O. Box 1527, Jefferson City, MO 65102-1527.
- Secretary of the Department of Health and Human Services, 200 Independence Avenue –SW, Washington, DC 20201.

Do you understand this policy? ☐ *Yes* ☐ *No*

Client Signature	Date	**Parent /Legal Representative Signature**	Date

This information is personal & confidential and will only be shared between you and your counselor.

Child/Family History

Name: _____ **Date of Birth:**_____/_____/_____

Who has custody of the child? _____

Are there any outside agencies involved? Y/N **If yes please explain who and why:**

_____

List people who live in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital Status of parents (circle): Married Separated Divorced Widowed Never Married

To what adult is he/she closest (mom, dad, grandparent, etc.): _____

Has there been any recent life changing events/disruptions? Y/N

_____

_____

_____

History of problem

Is your child experiencing now or have they experienced any of the following in the past 6 months:

____ Appetite change (more/less)
____ Difficulty sleeping
____ Fatigue/loss of energy
____ Difficulty concentrating/making decisions
____ Low self-esteem
____ Recurrent thoughts of death/suicide
____ Recurrent thoughts or acts of self-harm
____ Panic attack
____ Muscle tension
____ Fear of losing control
____ Anxiousness/nervousness
____ Wetting/bowel accidents
____ Academic problems: Grades Social Other
____ Bullying: If so, how:_____
____ Family Concerns: If so, how: _____

____ Loss of interest in activities/things
____ Depressed mood
____ Irritability/anger/agitation
____ Significant weight loss or gain
____ Feeling worthless
____ Feeling hopeless
____ Feeling keyed up or on edge
____ Excessive worry
____ Heart palpitations/racing
____ Nightmares
____ Day dreaming
____ Difficulty making friends

This information is personal & confidential and will only be shared between you and your counselor.

What concerns you most about your child? _____

_____

When did you first think there might be a problem? _____

_____

What do you think caused the problem? _____

_____

Have you noticed any changes in the patterns your child normally:

Eats: _____

Sleeps:_____

Is the problem worse at certain times, situations, places? _____

Has your child ever done any of the following?

Stolen/shoplifted____
Abused drugs/alcohol____
Ran away_____
Set fires____
Acted out sexually____
Been cruel to animals____
Physically assaulted anyone____

School History

School:_____**Grade:**_____

Special Services ***(circle all that apply):*** None LD BD EMR OT Speech

Has there been a noticeable change in grades? Y/N **If yes,when?**_____

Has he/she ever been suspended or expelled? Y/N **If yes, when?** _____

How does your child get along with others?_____

How many schools has he/she attended during the past three years?_____

Previous Mental Health Services

Has he/she received counseling services before? Y/N **If yes, when?**_____

Where? _____ **Reason for discontinuing?**_____

This information is personal & confidential and will only be shared between you and your counselor.

Has he/she had any psychiatric hospitalizations? Y/N **If yes, when?**_____

Where? _____ **Reason?**_____

Medical History

Child's personal physician: _____

Is the child on any prescription medications? Y/N
If yes, please list:

Medication (and dose)	**Condition**	**Prescribing Doctor**
_____	_____	_____
_____	_____	_____

Has he/she started puberty? Y/N **If yes, approximately when did it start?**_____

Do you have any medical concerns about your child?_____

_____

Developmental History

Were there any medical problems or complications during the pregnancy or birth for the mother or child? If yes, please describe:

_____

_____

Was this a planned pregnancy? Y/N **Child's birth weight** _____ lbs. _____oz.

During the pregnancy, did the mother use drugs, alcohol, cigarettes, or medications? If yes, please list:

_____

During the first year, how would you describe your child?: Cuddly___ Affectionate___
Sickly___ Colicky___ Poor Sleeper___ Easy to care for___ Difficult to care for____

Did you have any concerns with your child's development? If so,

describe:_____

_____

This information is personal & confidential and will only be shared between you and your counselor.

Family / Social History

If child does not live with both parents, what is the visitation arrangement with parent not in home? _____

Has the child ever lived with any other person beside parent? If yes, please explain (include relationship, dates):

_____

_____

Has he/she ever been abused physically, sexually, or emotionally? If yes, please explain:

_____

_____

_____

Has he/she ever witnessed violence in the home or had a severely traumatic experience? If yes, please explain:

_____

_____

How do you discipline your child?_____

Has this method been effective?_____

What chores does your child have? _____

Does he/she usually accomplish chores? _____

How much time does your child spend watching television per day? _____

Playing video games? _____

What are your child's strengths / good qualities? _____

_____

What hobbies, activities, and interests does your child enjoy being involved in?

_____

_____

How does your child interact with or get along with you?_____

_____

This information is personal & confidential and will only be shared between you and your counselor.

Does your child like/dislike self?_____

Is there anything you would like to add regarding your child? _____

_____

This information is personal & confidential and will only be shared between you and your counselor.

Read, sign and accept the policy below:

If parents are divorced or separated, we need to have the appropriate court documents in the child's records showing who has custody and who is responsible for seeking medical care/counseling if it is so indicated in the court document.

This office does not get involved in custody and financial disputes. The person signing for the responsibility for the child will be the person indicated as the one financially responsible for services rendered by our counselors. Any financial arrangements made between divorced/separated parents are to be handled between the parents.

I, (Parent/Client/Guardian), understand the above statements and agree that this is for the best interest of the Client.

I, (Parent/Client/Guardian), authorize the individual(s) listed below to make appointments for and/or bring the Client to the appointments on my behalf.

Print Name	**Relationship**
Print Name	**Relationship**
SIGNATURE OF PARENT/CLIENT/GUARDIAN	**DATE**