

CHILD YEARLY RENEWAL PACKET

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT

Welcome to *Parsons Counseling, LLC (PC, LLC.)*.

This document contains important information about our services and business policies.

Client Name: _____ Date: _____

Social Security #: _____ Birthdate: _____

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I hereby authorize the staff of Parsons Counseling, LLC. to render treatment and/or service to the client listed above. I understand that information or opinions will be given to others only with my written consent.

Relationship to client: self, parent, other (specify).

Signature of Client 16 and older or Parent/Guardian

Print Name

Date

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law including, specifically:

1. You consent in writing by signing a release of information, or
2. The disclosure is allowed by a court order and/or issued by a judge, or
3. The disclosure is made to medical personnel in a medical emergency, or
4. If you pose a threat of harm to yourself or an identified person, or
5. If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect.

State Law and Regulation do not protect any information about suspected child abuse or neglect, including spouse abuse. Kentucky law requires that child abuse and neglect be reported. In Kentucky, no one under the age of 16 can legally consent to sexual contact.

Initial here: _____

INTERNS: PC, LLC is working with qualified students to train them for the human services profession. They will maintain client confidentiality and maintain professionalism in the workplace. Interns will schedule appointments, work with clients, assist with intakes, and other office tasks.

Initial here: _____

APPOINTMENTS & TERMINATIONS: All office appointments are scheduled for 53 minute sessions. Consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time. If you are unable to keep a scheduled appointment, you must notify PC, LLC. **at least 24 hours in advance** to avoid the canceled or missed appointment fee of \$30.00. To cancel an appointment, you may choose to leave a message on voicemail, leave a text message at 859-428-7862, or email at appt@parsonscounseling.com. **Your compliance in keeping appointments and active participation in treatment is vital.**

- ❖ If you have not had an appointment for at least 60 days a letter will be sent to the address on file inviting you to schedule an appointment within 10 days before terminating your chart. **If you choose to schedule an appointment and do not show your chart will be terminated.**
- ❖ **If you cancel or miss three visits within a 90 day period PC, LLC. reserves the right to terminate your chart immediately & refer you elsewhere.**

Initial here: _____

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

Appeals and Grievances: If you have a complaint about the quality of care please contact the Practice Administrator by email at info@parsonscounseling.com within 30 days of the incident.

Initial here: _____

PAYMENT & INSURANCE REIMBURSEMENT:

- ❖ Clients paying on a **cash basis** are expected to **pay in full at the time of service** unless other arrangements have been made.
- ❖ **Additional fees** of \$100 an hour will be charged for lengthy telephone communications, court attendance, and report/letter writing. Insurance doesn't cover this.
- ❖ If your case requires us to hire an attorney to assist or protect our office involving your case you will be responsible for **all attorneys' fees**
- ❖ There is a **\$30.00 service fee for checks returned** for insufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay **in cash** the service charge **PLUS** the value of the check.
- ❖ I authorize my insurance to be billed for counseling services in an attempt to assist in paying for my services.
- ❖ At any time during treatment **should the client become ineligible for insurance coverage, the client and/or responsible party agrees to notify the counselor and will be responsible for 100% of the bill.**

Initial here: _____

CONSENT TO TREATMENT AND FEE:

By signing this contract, you agree that if we have not obtained any necessary authorizations from your insurance, or you are not eligible at the time services are rendered, **you are responsible for payment** even if the determination is made after the services are rendered.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign Parsons Counseling, LLC. and all insurance benefits due to me to the full extent of my financial obligation to Parsons Counseling, LLC. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Kentucky State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

Initial here: _____

HIPPA Notice of Privacy Practices

Please mark one of the following: _____ I have received a copy of the HIPAA Notice of Privacy Practice (available at the Center or on www.parsonscounseling.com)
_____ I decline to receive a copy of the HIPAA Notice of Privacy Practice

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them; I have been given an opportunity to discuss these policies with a Parsons Counseling, LLC staff person and all the questions I raised were answered to my satisfaction.

Signature of Client age 16 or older/Legal Representative Print Name Date

Signature of Parsons Counseling, LLC. Representative Date

CHILD'S CONTACT INFORMATION & PSYCHOSOCIAL

*Child's Name: _____ *Date: _____
 *Social Security #: _____ *Birthdate: _____ * Height: _____ *Weight: _____
 *Gender at Birth: M or F (If applicable) Gender Identity: _____ Sexual Orientation: _____
 *Address: _____
 *City, State, Zip: _____

FOR THE FOLLOWING LINES, please list information for the Parent(s) or Guardian(s) who have LEGAL CUSTODY of the client:

*Parent/Guardian 1 Contact Name: _____ *Relationship: _____
 *Phone _____ Circle: Home Cell Work *May we leave a message or text this phone? Yes No
 *E-mail _____ May we email you or put you on our mailing list? Yes No
 *Parent/Guardian 2 Contact Name: _____ *Relationship: _____
 *Phone _____ Circle: Home Cell Work May we leave a message or text this phone? Yes No
 *E-mail _____ May we email you or put you on our mailing list? Yes No

PARENT and GUARDIAN INFORMATION (all areas must be COMPLETELY filled out).

Note: If parents are separated or divorced, or the child lives with another guardian, a copy of custodial papers MUST be on file at Parsons Counseling, LLC. Counseling services will only be rendered to a child with a parent or guardian with legal documentation from a judge.

*Biological Mother's Name: _____ Does the child live with?: Yes or No **If no**, Visitation?: Yes or No
 *Biological Mother deceased? Yes or No
 *Biological Father's Name: _____ Does the child live with?: Yes or No **If no**, Visitation?: Yes or No
 *Biological Father deceased? Yes or No
 *Biological Parents are: ___Married ___Divorced ___Separated ___Never married
 *Do the biological parents have legal custody of the child? Yes or No
 • If not, has the child been legally adopted? Yes or No OR ● If not, is the child currently in foster care? Yes+ or No
 +If **yes**, list the social worker's name and cell phone number: _____

INSURANCE INFORMATION

****If you have Medicaid & other insurance in addition to Medicaid please list the OTHER insurance as the Primary Health Insurance. Medicaid will NOT pay if we do not bill the other insurance first. Ms. Lisa Parsons, Ms. Brittany Wills, Ms. Christina Bacon, Ms. Emily Downer, & Ms. Jeanne Nakazawa are currently the only participating therapists with other private insurances outside of Medicaid. If you have other insurance & see another therapist you will be responsible for the full intake fee of \$80.00.**
**** For Medicaid, the client is the subscriber; all other insurances an adult parent is the subscriber.**

*Primary Health Insurance: _____ *ID #: _____ Group #: _____
 *Subscriber Name: _____ *Child's Relationship to Subscriber: _____ *Subscriber DOB: _____
 *Subscriber Address: _____
 Secondary Health Insurance: _____ ID #: _____ Group #: _____
 Subscriber Name: _____ Child's Relationship to Subscriber: _____ Subscriber DOB: _____
 Subscriber Address: _____

CHILD'S CONTACT INFORMATION & PSYCHOSOCIAL continued

Problem Analysis - History of Present Problem

PROBLEM DESCRIPTION: Briefly describe the current presenting problem(s) your child is presenting with: _____

CHANGES: Briefly describe any changes your child may have shown since beginning therapy:

PROBLEM INTENSITY: How would you rate the intensity of the problem or concern the child has been experiencing? (Circle the appropriate number):

1 2 3 4 5 6
 Not intense Moderately Intense Extremely Intense

PROBLEM DURATION: Approximately how long has the child had the current problem? _____

COPING ATTEMPTS: In what ways has the child or family attempted to cope with this problem since beginning therapy?

EXPECTATIONS: What do parent/guardian hope to accomplish by continuing therapy? _____

ADHD and concentration issues: On a scale from 1-10 with ten being extremely hyperactive or inattentive, how is the child? ____

DEPRESSION: On a scale from 1-10 with ten being extremely depressed/suicidal, how depressed is the child? _____

ANXIOUS: On a scale from 1-10 with ten being extremely anxious, how anxious is the child? _____

HOSPITALIZED: Has the child ever been hospitalized for psychological/emotional difficulties since beginning therapy? ___ Yes

___ No

If yes, explain difficulty, dates hospitalized _____

SUICIDAL: Has the child had suicidal thoughts recently? ___frequently ___sometimes ___rarely ___never

Has the child had suicidal thoughts in the past during therapy? ___frequently ___sometimes ___rarely ___never

Has the child attempted suicide since being in therapy? ___Yes ___No ___Unsure

CUTTING/OTHER: Has the child intentionally inflicted any harm upon self since being in therapy? ___ Yes ___ No ___ Unsure



Check all that apply:

Accident prone
Affectionate
Aggressive
Argues, "talks back," smart-alecky, defiant
Assaults
Bathroom language
Bigoted
Bossy to others
Breaks rules
Breaks the law
Bullied by others
Bullies/ intimidates, teases, inflicts pain on others
Cheats
Clowns around
Competition
Complains
Complains of feeling sick
Compliant
Concern for others
Conflicts at school
Conflicts at home with parents over rule breaking, money, chores, choices
Conflicts with friends
Conflicts with police
Cries easily, feelings are easily hurt
Cruel to animals
Dares others
Dawdles, procrastinates, wastes time
Daydreams
Defiant
Dependent, immature
Destructive
Developmental delays
Difficulties with parent's paramour/new marriage
Disobedient, uncooperative, refuses, noncompliant
Disrupts family activities
Distractible, inattentive, poor concentration, daydreams
Dropping out of school
Drug or alcohol use
Drug sales
Eating issues, poor manners, over/under eats, refuses
Exercise problems
Extracurricular activities interfere with academics
Failure in school
Fantasy life
Fearful
Feelings are easily hurt
Fidgety
Fighting, hitting, violent, aggressive, hostile, threatens
Finger sucking
Fire starting
Fire setting
Friendly, outgoing, social
Hair chewing, pulling

Head banging
Hitting
Hostile
Hyperactive
Hypochondriac, always complains of feeling sick
Imaginary playmates, fantasy
Immature, "clowns around," has only younger playmates
Inappropriate sexual behaviors
Inattentive
Independent
Inflicts pain on others
Insults others
Interrupts, talks out, yells
Intimidated by others
Intimidates others
Intolerant
Irritability
Isolates
Lacks organization, unprepared
Lacks respect for authority, insults, dares, provokes
Learning disability
Legal difficulties, truancy, loitering, vandalism, drinking
Lethargic
Likes to be alone, withdraws, isolates
Loitering
Loss of friends
Low-frustration tolerance, irritability
Lying
Manipulates
Masturbation
Mental retardation
Moody
Mute – refuses to speak
Nail biting
Name calling
Needs high supervision at home over play/chores/schedule
Negativism
Nervous
New school
Nightmares
Noisy
Noncompliant
Obedient
Obesity
Only younger playmates
Oppositional, resists, refuses, does not comply, negativism
Outgoing
Out-of- seat behaviors
Overactive, restless, hyperactive, restlessness, fidgety
Picks on others
Poor concentration
Prejudiced, bigoted, insulting, name calling, intolerant

Procrastinates
Provokes others
Rages
Recent move, new school, loss of friends
Refuses
Relationships with friends are poor
Relationships with siblings –competition, fights, teasing/provoking
Relationships with teachers poor
Resists
Responsible
Restless
Rocking motion/behavior
Repetitive movements
Runs away
Sad, unhappy
School avoiding
Self-harming behaviors—biting, hitting self, scratching
Sexual preoccupation, inappropriate sexual behaviors
Sexually active
Shy, timid
Slow moving
Slow responding
Smart-alecky
Smoking
Social
Speech difficulties
Stealing
Stubborn
Suicide talk or attempt
Swearing, blasphemes, foul language
Talks back
Teased, picked on, victimized, bullied
Teases others
Temper-tantrums, rages
Threatens
Thumb sucking, finger-sucking
Tics – involuntary rapid movements, noises or word productions
Timid
Truancy, school avoiding
Uncooperative
Uncoordinated, accident-prone
Underactive, slow-moving
Unhappy
Unprepared
Vandalism
Violent
Wastes time
Wetting/soiling of bed or clothes
Withdraws
Yells

Other:

Initials of Parsons Counseling, LLC Rep.

MEDICATION RECONCILIATION RECORD for ALL MEDICATIONS

Client Name: _____ Birthdate: _____

Date: _____

No Known Allergies OR List Allergies:

Current Medications: *Prescribed medications, herbal supplements, vitamins, over-the-counter drugs, everything that you are taking on a regular basis for any reason.*

Medication Name	Dose and Frequency	Date Started	Date Discontinued	Reason for Taking It	Prescriber (first and last name with specialty)

Initials of Parsons Counseling, LLC. Representative: _____

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Child

Client Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Parsons Counseling, LLC. to use or disclose protected health information from the mental health records of the client listed above, which may include psychiatric diagnosis, treatment plans, and progress (written, verbally or electronically) to the following and initial for my consent:

I do not have a PCP I do not consent permission for my PCP to be contacted

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Inform physician of therapeutic services and any medical or mental concerns.

***Psychiatrist or Prescribing Doctor of Psychotropic Drugs (if applicable):**

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate and obtain medical information from the physician to assist in meeting any medical, medication, or mental concerns.

School County District/ Daycare:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: To work with teacher, family resource/youth service center, counselor, or principal regarding behavioral or mental health concerns to assist in school performance.

***Emergency Contact:**

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: In case of a medical emergency and scheduling appointments.

***DCBS or Agency who has custody of child (if applicable):**

County: _____

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: To report progress and therapeutic goals regarding behavioral or mental health concerns to assist in reaching DCBS or agency goals & obtain a copy of most recent Family Prevention Plans/case plans. .

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Child

***Other Parent/Step-parent/ Guardian:**

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Appointments, progress of treatment goals, concerns, and areas where adult can make improvement to assist client.

Legal or other:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: _____

By signing below, I acknowledge that I have read and understand this Authorization.

1. I understand that, unless withdrawn, this authorization will expire in one year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Parsons Counseling, LLC. at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that Parsons Counseling, LLC will NOT give copies of client notes without another release signed indicating such.
5. I understand that I may inspect or copy my mental health records.
6. I understand that I may refuse to sign this authorization and that Parsons Counseling, LLC. will not allow my refusal to interfere with receipt of payment for mental health and counseling services.
7. I understand that I am entitled to receive a copy of this authorization

Signature of Client age 16 or older/ Legal Guardian

Relationship to Client

Date

Signature of Parsons Counseling, LLC. Representative

Date

RELEASE OF INFORMATION TO PROVIDE IN-SCHOOL & IN-DAYCARE COUNSELING & TARGETED CASE MANAGEMENT

I hereby authorize Parsons Counseling, LLC to provide in-school, in-daycare counseling, and/or targeted case management services to the following client listed below. I understand that the client will be taken out of class for 30-60 minutes at the counselor/ case manager's discretion and may be seen with Parsons Counseling staff in public areas of the school or daycare. The client will be seen in an office or space provided by the school or daycare to conduct counseling in lieu of counseling offered at Parsons Counseling & Play Therapy Center.

Client's Name: _____

DOB: _____ **SS#:** _____

Address: _____
 (street) (city) (state) (zip)

Daycare/School Information

***Parsons Counseling, LLC only goes to select participating schools in the Madison County/Estill County area. Please ask to see if your child's school is one of those participants.**

County District: _____ (Madison County Schools have their own form to fill out too.)

Daycare/School Name: _____

Address: _____
 (street) (city) (state) (zip)

Parent or Guardian's Name consenting for services: _____

Parent or Guardian's Number: _____

Additional agreement: I agree to have the following information disclosed and to exchange information to the school or daycare staff and counselor and/or TCM Coordinator:

- Attendance Records Behavior Issues Academic information
- Summary of treatment progress verbal or written Progress in counseling and/or TCM services
- Other (specify) _____

For DayCare clients:

- I understand and agree that the daycare setting may be used as a therapeutic playroom with the child, resulting in some treatment in public settings.
- I do not agree to therapeutic playroom activities in public settings at the daycare.

****This consent is effective for one year from the date signed below or _____.****

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Parent/Legal Guardian Signature: _____ **Date:** _____