Counseling Services Agreement

Brieanna Claassen, MA, LPC, CPT

Welcome! The following information is provided to clarify the nature and limitations of the counseling services that I offer.

Therapeutic approach – I conduct individual and family counseling utilizing an attachment theory and family systems-based approach, and my preferred modality of treatment is Emotion- Focused Therapy for adult individuals and couples and Child-Centered Play Therapy for children; however, techniques from other theoretical perspectives may be integrated where necessary and appropriate according to the needs of each individual client. If you or I find that your needs are not being met by my services, I may refer you to another mental health professional with your consent.

Credentials – I am a Licensed Professional Counselor (LPC) in the state of Kansas as well as a National Certified Counselor (NCC) and a Certified Play Therapist (CPT). I have a Master of Arts in Marriage, Couple, and Family Counseling from MidAmerica Nazarene University. I am a member of the American Counseling Association and the Association for Play Therapy and abide by the ethical codes delineated by these professional associations. I am not a physician and do not have authority to prescribe medication.

I am currently under supervision, a process required in the state of Kansas in order to obtain clinical licensure. My supervisors are Danna Dahl, LCMFT, LCPC (913-491-6876 ext. 102) and Dr. Todd M. Frye, PhD, LCPC, LCMFT, SATP-S (913- 626-1387). Supervision ensures you receive the highest quality of care.

Benefits and risks of therapy – Any time individuals seek therapy to work on difficulties within themselves or in their personal relationships, there are potential benefits and risks. Benefits may include the ability to handle specific concerns and/ or interpersonal relationships in a healthier way. Clients may also gain a greater understanding of personal, interpersonal, or family issues. This new understanding may lead to greater maturity and happiness as an individual or family. There may also be other benefits that come as clients work at resolving specific concerns.

However, therapy is also sometimes challenging and uncomfortable. Reviewing and resolving unpleasant issues may result in intense feelings of anxiety, anger, depression, or frustration. As clients work to resolve personal issues or issues

between family members, peers or other persons, they may experience discomfort and an increase in conflict. Changes in relationships that were not originally intended may also result.

I will discuss with each individual/family the benefits and risks involved in their specific situation. Clients are encouraged to discuss with me concerns they may experience at any time.

Confidentiality – The code of ethics for counselors (ACA), federal laws, and state laws regulating the practice of counseling regard personal information you discuss to be confidential. A record of the health care services I provide for you is kept in a locked file, and unauthorized access to this file is prohibited. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so by exception as described below.

1) Information may be disclosed in supervision to ensure you receive the highest quality of care.

2) If I become aware that a child under 18, a developmentally disabled person, or an elderly person is or has been abused, a report must be made to the appropriate authorities.

3) If a client threatens another person, I must protect the other person(s) by warning the person(s) at risk and reporting the danger to the appropriate authorities.

4) If a client poses a danger to self or others or is unable to take care of basic needs, I will take appropriate action to protect the client's safety.

5) If a client chooses to submit reimbursement claims to an insurance provider, the insurance provider has the right to some limited information about the client's treatment.

6) If a subpoena is received for the client's records.

7) If the client requests that information be released to a third party such as a physician or a school, I will fill out a release of information form with you at that time.

For convenience, you may choose to communicate with me via email (brie@claassencounseling.com). You must be aware, however, that email is not encrypted and therefore not entirely secure. In addition, to ensure confidentiality as well as the safety of both client and counselor, you must not search for, follow, or friend any of my personal social media pages at any time. I will not search for, follow, or friend the social media pages of any clients or their family members. Furthermore, you must take precautions when commenting on my professional website.

If I happen to see you outside of the counseling context, I will keep our association private and will not attempt to communicate with you unless you initiate contact with me. If you initiate contact with me in a public place, please be aware of the ramifications if you do not wish those around you to know that you are receiving counseling services.

Billing Policy – All counseling fees are due at the time of service. I accept checks, money orders, cashier's checks, HSA account cards, and credit/debit cards. Your payment responsibilities for the services you will receive are as follows, unless otherwise agreed upon:

- Payment at $85/hour for individual counseling services or $105/hour for couple/family counseling services will be collected at the time of your session. Sessions are 50 minutes long (the remaining 10 minutes of the hour are reserved for documentation purposes). If you and I agree to schedule a longer appointment for any reason, you will be billed accordingly.

- **Because your counseling appointments are reserved especially for you, you are required to give me at least 24 hour advance notice if you wish to cancel or reschedule an appointment. If you do not give the required notice, you will be billed for your missed session in the amount of your session fee. Similarly, if you do not call me and do not show up for your appointment, you will be billed the amount of your session fee. Finally, it is your responsibility to show up to your appointments on time. If you are late, your session will still end at the time originally scheduled, and you will be billed the full amount of your session fee. If you are more than 20 minutes late, I reserve the right to cancel your appointment and bill you the full amount of your session fee.**

- If a check is returned by the bank due to insufficient funds, you will be charged a $30 NSF fee, and I will require that all future payments be made by cash, money order, cashier's check or credit card.

- I do not accept insurance, am not on any insurance company panels, and will not bill insurance directly. I can provide you with a superbill that details services rendered, payments made, and diagnosis (if applicable) which you may submit to your insurance company for reimbursement. It is your responsibility to check with your insurance company regarding what will and will not be covered under your out-of-network insurance benefits. You are responsible for your bill in full at the time of service, even if your insurance company will not reimburse you. I make no guarantees regarding insurance coverage of any type or amount.

- In unusual circumstances, you may become involved in litigation, which may require my participation. You will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, the charge will be $200 per hour for preparation for, travel to and from, and attendance at any legal proceeding.

- You will be billed for any communication outside of our counseling sessions that takes longer than 10 minutes to either discuss by phone or read by email. Please keep this in mind if you plan to communicate with me between sessions or have a third party consult with me about your case for any reason. You will be billed per hour at the same rate that you pay for your counseling sessions for all communication exceeding 10 minutes.

- If a balance is owed on your account for any reason, this amount is due 30 days following your receipt of the bill for unpaid charges. Failure to bring your account up-to-date may result in the transfer of your account to a collection agency.

- I may be away from the office several times in the year for vacations or for other personal reasons. I will tell you well in advance of any lengthy absences and will give you the name and phone number of the counselor who will be covering my practice during my absence. There may also be occasions when I have to cancel at very short notice for reasons of personal illness or family emergency. For missed sessions in such instances, or for any other sessions that are cancelled by myself for any reason, you will of course not be billed. If you are experiencing an emergency when I am out of town or unavailable, or outside of my regular

office hours, please call 911, or go to the nearest hospital emergency room for assistance.

Statement of Informed Consent – My signature below indicates that:

1. I have read, understand, and agree with the counselor's policies and give informed consent to receive counseling services.

2. I understand that there can be risks and benefits associated with counseling. I also understand that no promises have been made to me as to the results of treatment.

3. I understand that I may leave counseling at any time.

4. I acknowledge receipt of a copy of this Agreement and the Notice of Privacy Practices.

5. I have read and agree to the above billing policy. I agree to pay a fee of $_____. I also agree to pay for missed appointments or for appointments I cancel without giving the required 24-hour advance notice as stated in the billing policy.

_____

Print Client Name Client (or Legal Guardian) Signature Date

_____

Brieanna Claassen, MA, LPC, CPT Date

Notice of Counselor's Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO). It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services. Please review it carefully. You have the right to a paper copy of this Notice; you may request a copy at any time.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.
• "Treatment, Payment, and Health Care Operations"
• Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
• Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to help you obtain reimbursement for your health care or to determine eligibility or coverage.
• Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
• "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
• "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your assessment results and report. "Assessment Results and Report" are notes I have made about our conversation during an intake session, answers and test scores derived during a testing session, scored test forms and computer printouts, and the written summary of the evaluation, which includes test scores, diagnoses, and history.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:
• Child Abuse – If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.
• Adult and Domestic Abuse – If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
• Health Oversight Activities – I may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
• Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization from you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
• Serious Threat to Health or Safety – If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to

protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
• Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:
• Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
• Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
• Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
• Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties:
• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I reserve the right to change the privacy policies and practices described in this notice.
Unless I notify you of such changes, however, I am required to abide by the terms

currently in effect.
• If I revise my policies and procedures, I will provide you with a revised notice by U.S. Postal Service.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at (913) 712-0912. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on April 14, 2003.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT IT CONTAINS.

_____

Print Client Name Client (or Legal Guardian) Signature

_____

Witness Date

Physician Release/Waiver

By Kansas statute, I am required to consult with your primary care physician or psychiatrist to determine if there is a medical condition or medication which may be contributing to your symptoms. However, you are able to waive this requirement if you choose to. In this case, I would not contact your physician at this time; however, if it is deemed necessary at any later point during your treatment, we can sign a release of information at that time. If you choose to waive the physician contact, please sign below.

I waive my right for you to contact my physician. I do not wish for you to consult my physician at this time.

_____

Client (or Legal Guardian) Signature Date

If you choose to have your therapist contact your physician, you are required to provide me with the name and mailing address of your physician.
Please contact my physician:

Dr._____

_____

Address Phone

_____

Client (or Legal Guardian) Signature Date

Client Information

Name _____ Date of Birth _____

Address _____
Street City State Zip

Emergency Contact (name and phone number) _____

Please provide contact phone number(s) and indicate your preferred number.

_____Leave a message? __ yes __ no Preferred? __ yes __ no
Home Phone
_____Leave a message? __ yes __ no Preferred? __ yes __ no
Cell Phone
_____Leave a message? __ yes __ no Preferred? __ yes __ no
Work Phone
_____OK to E-mail? __ yes __ no OK to Text? __ yes __ no
E-mail Address

Referred by _____
Do I have your permission to thank the person who referred you? __ yes __ no

RELIGIOUS AND SPIRITUAL
Do you consider yourself spiritual? __ yes __ no Religious? __ yes __ no

Comment?_____

Do you currently express this spirituality through religious practice? __ yes __ no

Comment?_____

Would you like spirituality included in your counseling? __ yes __ no

BACKGROUND AND PRESENTING PROBLEM

Occupation & Employer _____

Ethnicity_____ Marital Status _____

If you have been or are married, please provide dates for marriage(s), separation(s) and divorce(s):

_____

Please describe the problem or situation which led you to seek our services at this time:

_____

_____

_____

_____

How long has this been a problem? _____

Have you experienced this type of problem before? _____ If so, when? _____

_____

Have you ever had counseling before? _____ If so, when and why?_____

_____

Was it helpful? _____ If not, why not?_____

_____

Have you ever had medication prescribed for psychiatric or emotional difficulties? _____ If so, please list medications and diagnoses:_____

_____

Have any other biological relatives had problems similar to yours, or had any psychiatric or emotional difficulties? __ yes __ no

If so, which relatives and what kind of problems? _____

_____

Presenting problems: (check all that apply)

□ Very unhappy □ Lacks initiative □ Shy □ Irritable
□ Impulsive □ Self-mutilating □ Repetitive/ritualistic behaviors
□ Slow □ Violence □ Suicidal thoughts □ Stubborn
□ Hair Pulling □ Stealing □ Sexual problems □ Short attention span
□ Panic attacks □ Relationship issues □ Overactive □ Temper outbursts
□ Undependable □ Daydreaming □ Destructive □ Crying spells
□ Worry □ Health problems □ Grief □ Strange thoughts
□ Alcohol use □ Sexual abuse □ Sleeping problems □ Withdrawn
□ Mean to others □ Social problems □ Fearful □ Legal problems
□ Distractible □ Strange behavior □ Drug use □ Employment issues
□ Eating problems □ Lying □ Parenting problems □ Stressed out
□ Physical abuse □ Financial stress □ Homicidal thoughts

Explain symptoms marked above: _____

_____

What are the strengths that you bring to therapy? _____

_____

_____

What are your goals for treatment? _____

_____

_____

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

_____

_____

_____

_____