Warner Family Counseling
Kaylene Warner LCSW

Welcome to my practice. ***My job is to provide you with an empathetic and non-judgmental environment where together we can identify the areas of your life you would like to change. We will examine how your negative thoughts can keep you from making those changes.***

General Policies

If you will be utilizing your managed care benefits please complete the following ***PRIOR TO OUR FIRST MEETING:***

Contact your member services number (on the back of your insurance card) and request information regarding your Behavioral Health Benefits, specifically Outpatient Psychotherapy Services, to determine:

(a) Is Kaylene Warner LCSW in my network what are my in-network benefits?
(b) Do I have a deductible? Have I met my deductible? What is my copay or co-insurance amount? When does my deductible start over?
(c) Ask if there are any pre-authorizations required – if so, make sure they are activated and bring the authorization number to your first session.
(d) Are the services I am needing covered under my plan? Individual, couples, etc

As a patient **you are responsible for all co-payments, deductibles, and various non-covered fees by your plan at the time services are rendered.** If benefits are unknown at the time of service a you may be responsible for the hourly billing fee of this provider. Claims will be filed a total of 2 times by this provider. Any services not reimbursed to the provider for by the insurance company after this process will be charged to the credit card on file. At this point it will be your responsibility to collect fees from your insurance company. Insurance companies only reimburse for specific services. This office is not responsible for noncoverage of services.

As an out of network provider, I will provide a financial receipt for you to file with your insurance company.

Emergencies: I do not provide emergency services, although I strive to be as accessible to you as possible. You may call the office number at any time and leave a message if I do not answer. Generally, I attempt to return calls within 24 hours.

IF you find yourself in an emergency situation please call 911 or go to your nearest emergency room for immediate care.

Other Fees:

*Report preparation or progress summary of counseling services that is requested or required, the time rate charged for outpatient sessions will be applied in 15- minute increments.
*Telephone calls longer than 10 minutes will be charged at my hourly rate. Minimum 15-minute charges.
*This provider ***DOES NOT*** fill out disability paperwork. Please contact your treating physician to help with this.
* Because I can't guarantee your privacy via e-mail I ask that emails be limited to cancelling or rescheduling appointments, it is not my practice to facilitate emails pertaining to treatment issues. I ask that we discuss treatment issues face to face at your next session.

Legal Fees:

If you are presently involved in any legal proceedings please let me know at the beginning or treatment. Additionally, if you become involved during the course of treatment please let me know immediately. If Ms. Warner is requested by her client or subpoenaed by any attorney to testify in any court-related proceeding as a result of the therapeutic relationship, she will produce the requested information if she is required to do so by law. Ms. Warner may be required to show the court her records and/or testify in court. The client will be required to reimburse Warner Family Counseling in advance at the rate of $450/hour for the following applicable records: production of any form or report pertaining to records, preparation/review time concerning depositions, preparation time for court, travel time to/from depositions and court, waiting time at deposition and court, time in deposition and court. A minimum of 4 hours totaling $1350 is required to be paid before **any** work begins in a case.

Counseling Service Fees:

Diagnostic & Evaluation session $150.00
ADD/ADHD evaluation session $150.00
Individual 50-minute session is $140.00
Couples 50-minute session $150.00
Couples 90-Minute Session $225.00
Family 50-minute session $160.00
Family Sessions 90-minutes session $230.00
Late Cancellation, less than 24-hour or one business day notice $150
Missed Appointment $150
Returned check fee per check $75
Credit Card Cash backs or Declines $60
*Initials _____

Payments for services may be made with Cash or Credit Card. Checks will be accepted on a case by case basis. In the case of an outstanding balance regarding a returned check the credit card on file will be used to collect these charges immediately

Please make note of the Cancellation Policy

Cancellations: Scheduled appointment are reserved for you. If you fail to come to your appointment or you give less than a 24 hour notice ***you will be charged $150***. The credit card on file will be charged in the amount owed by the end of business day in which the session was scheduled. After two consecutive absences, Ms. Warner may, at her discretion terminate services and provide referrals. *Initials _____

Counseling Relationship: During the time you work together with Ms. Warner, you will meet regularly for approximately 50 minutes per session. Although our session may be very intimate psychologically, we have a professional relationship, not a social one, as a social relationship might lead to exploitation of clients and impair objectivity in the professional role. Ms. Warner's services will be rendered in a professional manner consistent with accepted legal and ethical standards. If you have problems with your counseling relationship, it is encouraged that you speak directly with her. While benefits are expected from counseling, specific results are not guaranteed. As a client, you have the power to refuse or discuss modification of any of her counseling techniques or suggestions. Both the client and Ms. Warner have the right to withdraw from the therapy process. If the counseling process is withdrawn from, Ms. Warner will provide appropriate referrals upon the client's request.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. A commitment by a client is needed for continued treatment. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and /or your understanding of yourself. Some of these changes may be temporarily distressing. The exact nature of these changes cannot be predicted. Together, you can work with your therapist to achieve the best possible results for you.

Emergency/Crisis Situations: Ms. Warner has 24-hour voicemail at 972-539-3948. Ms. Warner ***does not*** provide a 24-hour crisis counseling service. If in a life-threatening situation, please call 911, go the nearest emergency room, or contact your PCP or psychiatrist. Please notify Ms. Warner if an "after hours emergency" has occurred so that a follow-up session may be scheduled as soon as possible.

Defamation of Character: By signing this consent form below you agree that you will not make defamatory comments about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Relationship Outside of Therapy I do not engage in relationship with my clients outside the office. I do not "Friend" or otherwise engage my clients using social media. If I receive a Friend or other request to connect with you online I will ignore it. This does not mean I don't like you. This is a practice I engage in with all my clients and it protects your boundaries as well as my own. Please understand that many clients prefer to keep this therapeutic relationship confidential and feel uncomfortable seeing me out in the community, which does happen from time to time. If I see you in public, I will only acknowledge you if you acknowledge me first. I respect that you have a right to privacy in this relationship, even when you are outside this office.

Discontinuing Treatment: I understand that I am free to discontinue treatment at any time and that I agree to notify Kaylene Warner LSCW immediately so that I may be provided with referrals for continued care. Additionally, Kaylene Warner LCSW has the right to terminate my treatment at any time. Some of the reasons include but are not limited to: boundary violations, non-compliance with treatment, failing to follow appointment policies and procedures, and non-payment of fees and/or services rendered. Should your therapist decide to discontinue treatment, you will be provided notification of such and a referral source for another psychotherapy professional or agency, if requested.

Confidentiality: Your relationship with Kaylene Warner is important and confidential. Information cannot be released regarding your counseling without your written consent unless disclosure is required by state law. Examples are:
1) suspected child or elder abuse,
2) third party payments such as insurance,
3) involvement in a legal case, your therapist may be required by law to release your records to attorneys or judges,
4) therapist concern with client being dangerously close to harming self or others. Your counselor may notify medical or law enforcement personnel.
Part of providing quality care is respecting your privacy rights and maintaining confidentiality of all your records pertaining to therapy. Kaylene Warner will not use or disclose your health information for any purpose not described in this notice without your written authorization.

Consent to Treatment

I do hereby seek and consent to take part in the confidential treatment by Kaylene Warner LCSW. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that after the final session or in the event that I have not attended a therapy session in thirty days, unless prior arrangements have been made, the client/therapist relationship will be considered closed unless I initiate further contact.

HIPPA Requirements/Privacy Act

Federal regulations (HIPPA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for services I provide, and for other professional activities. Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices at any time on this website. Kaylene Warner LCSW is required by law to abide by the terms of this Notice of Privacy Practices, allow you to review this Notice prior to granting consent, and notify you of changes/revisions to this Notice. If you believe your privacy rights have been violated, you may submit a written complaint to Kaylene Warner LCSW or to the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. Your Private Health Information (PHI) Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your healthcare record is the physical property of Kaylene Warner LCSW, but you have certain rights to restrict some of the uses or disclosures of the information contained in your healthcare record. Kaylene Warner LCSW however, has the right to use and disclose the information contained in your healthcare record in the process of providing treatment, receiving payment and performing other regular health operations such as: • Documenting and describing the care you received for legal purposes • Communicating with other healthcare providers who may be involved in your case • Educating health care professionals • Evaluating and improving the care you receive and the outcomes achieved • Billing and verification of services provided to you Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of Kaylene Warner LCSW. She is required by law to maintain privacy and confidentiality of your health information.

Your signature indicates you have read, understand and accept this document (Professional, HIPPA, Privacy and Informed Consent Policies) and that any questions you had about this document were answered to your satisfaction, and that you were

furnished a copy of this document online. By your signature, you issue consent for Ms. Warner to provide counseling, you understand your financial obligations and acknowledge your commitment to conform to these document specifications.

I have read and agree to set fees provided in this document.

I understand that my credit card on file will be charged for any no show, cancellation fees, check returned, cash back/declines on credit card, and outstanding balances for denial on insurance claims.

Cancellations: Scheduled appointment are reserved for you. If you fail to come to your appointment or you give less than a 24 hour notice ***you will be charged $150***. The credit card on file will be charged in the amount owed by the end of business day in which the session was scheduled.

***Card Number:** _____
3 Digit Verification Code (on back of card)_____**Expiration Date**: _____
Address, including zip code, where CC bill is sent: _____
_____

I have read the HIPPA Requirements for Ms. Warner and Warner Family Counseling

I have read and understand the Counseling Relationship, Effects of Counseling, Defamation of Character, Relationship Outside of Counseling, Discontinuing Treatment, and Confidentiality Sections in this document.

Print Name_____ Date _____

Client Signature_____ Date _____

Print Name_____ Date _____

Client Signature_____ Date _____

Client Signature, Parent/Guardian_____ Date_____
(If under 18 years of age)

Counselor Signature_____

Consent to Treatment for a Minor

I give my consent to my therapist to provide assessment and therapeutic services to my child. I understand that my therapist will work with him/her to develop a treatment plan and treatment will be formulated to resolve his/her problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my child's scheduled appointments and understand that failure to do so more than two times may result in his/her care being terminated. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my child.

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for my child's treatment.

Name of Child _____

Date of Birth

_____

Client Signature/Responsible Party Date

Warner Family Counseling
Kaylene Warner LCSW

Name _____ Date of Birth: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Occupation: _____
Best Phone Number to Reach You: _____
Is it okay to leave a message at these numbers? Y N
Email Address: _____

Partner Information (or parent information if client is a minor)

Name: _____ Date of Birth: _____
Relation: _____ SSN: _____
Address: _____ Zip Code: _____
City: _____
Employer: _____ Occupation: _____
Best Phone Number to Reach: _____
Is it okay to leave a message at these number? Y N

Insurance Information (if therapist is billing insurance)

Name of Insurance Company: _____ ID#: _____
Owner of Policy: _____ Policy/Group#:_____
Policy Owners Date of Birth: _____Insurance Company Phone #: _____
Insurance Claims Address: _____
Has your deductible been met this calendar year?_____Copay Amount: _____

Marital Status

Married Length of present marriage: _____ Previous marriage:_____
Single, Divorced, How Long: _____ Widowed, How Long: _____
Single, Never Been Married

Family Information

Child Name	*Sex*	*Age*	*With whom does child live*

List any other individuals living in the home:

Is there any family history of mental illness or substance abuse? Please explain.

Presenting Problem

Please list the reasons that bring you here today. This may include certain problems, issues, significant losses or changes that are causing you stress.

1.
2.
3.
4.

You're Goals in Counseling

Goals are very important in counseling. They provide me with a focus and direction that will help us to help you. Please list the goal (s) that you hope to address and achieve in counseling. Please be as specific as possible.

1.
2.
3.
4.

Risk Assessment

Please list family, friends, support and community groups which are helpful to you.

List any history of emotional, physical, and/or sexual abuse:

_____

_____

Have you been having any thoughts of harming yourself or others? □ Yes □ No
If so do you have a plan? Is so, please provide details: _____

_____

Are there any guns in your home? Please provide details:_____

_____

Medical History & Information

Are you being treated by a physician for any medical treatments? Please describe.

_____

_____

Are you currently taking any medications? List medication and dosage.

_____

_____

Who is your physician? _____
Last visit? _____Follow up date: _____

Previous or Current Counseling

Have you engaged in counseling services prior to this visit? □ Yes □ No
In what way was it helpful? Primary purpose?_____

_____

Emergency Information

Emergency Contact Person Name and Number _____
Do I have permission to contact this person if you are in need of emergency assistance?
□ Yes □ No

Referral Source

How did you learn about this office? _____