# 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 ("client") 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 you have a deductible? Have you met my deductible? What is your copay or co-insurance amount? When does your 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 you need covered under your 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, you will 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 by the insurance company after this process will be charged to the credit card on file upon receipt of the second denial of payment. It will then be your responsibility to receive reimbursement from your insurance company. Insurance companies only reimburse for specific services. This provider is not responsible for noncoverage of services.

**As an out-of-network provider, I ("therapist/provider") will provide a financial receipt for you to file with your insurance company**.

Payments for services may be made with Cash or Credit Card

***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. The time rate charged will be applied in 15-minute increments.

*This provider ***DOES NOT*** fill out disability paperwork. Please contact your treating Physician/psychiatrist for assistance.

* This provider cannot guarantee your privacy via e-mail, therefore I ask that emails be limited to cancelling or rescheduling appointments. Any emails exchanged are subject to placement in your case file. 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 of treatment. Additionally, if you become involved in any legal proceedings during the course of treatment, please let me know immediately. If I am requested by a client, or subpoenaed by any attorney, to testify in any court-related proceeding as a result of the therapeutic relationship, I may be required to provide records and/or testify in court. The client will be charged at a rate of $500 per hour to Warner Family Counseling in advance 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, and time in deposition and court. A minimum of 4 hours totaling $2000 is required to be paid before **any** work begins in a case.

***Counseling Service Fees:***

ADD/ADHD evaluation session $160.00. This type of evaluation is not covered by managed care benefits. It will be a fee for service session.
Individual 50-minute session is $160.00
Couples 50-minute session $170.00-Extended sessions charged in 15-minute increments
Couples 90-Minute Session $305.00
Family 50-minute session $180.00
Family Sessions 90-minutes session $320.00
Late Cancellation, less than 24-hour or one business day notice $150
Missed Appointment charged at hourly rate
Credit Card Cash backs or Declines $75

*Initials _____

This provider strives to price services fairly and competitively in the area.

# *Please make note of the Cancellation Policy*

***Cancellations:*** Scheduled appointments 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. I understand that emergencies and health problems do come up and I am willing to consider them when adequate notice is given. However, no shows, last minute scheduling conflicts with other professionals, sports events, family events, generally will not be considered. After two consecutive absences, this provider may terminate services and provide referrals. *Initials _____

***Counseling Relationship***: During the time you work together with this provider, 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. A social relationship might lead to exploitation of clients and impair objectivity in the professional role. This provider'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 me. 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 my counseling techniques or suggestions. Both the client and this provider have the right to withdraw from the therapy process. If the counseling process is withdrawn from, this provider 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***: This provider has 24-hour voicemail at 972-539-3948. I ***do 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 this provider 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 allow the therapist to provide confidential information necessary to rebut or defend against, or prosecute claims for, the defamation. "Defamation of Character" defined as someone making a false statement about you that causes some type of harm. The statement being published (meaning some third party must have read/heard it) and it must result in harm, usually in reputation. This includes any social media including, but not limited to, Facebook, Twitter, Yelp, Google, etc. I ask that any complaints or concerns be addressed directly with myself either verbally or written in hopes a resolution can occur speedily and seamlessly.

***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:*** You may discontinue treatment at any time and agree to notify this provider immediately, so that I may provide referrals for continued care. Additionally, this provider has the right to terminate 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 this provider decide to discontinue treatment, you will be provided notification of such and a referral source for another psychotherapy professional or agency, if requested. A case will be considered ***CLOSED*** after 30 days of non-communication unless warranted by a set timing of appointments ie. every 30-60 days for check-ins. At the time of re-establishment, a client may be referred out if this provider deems the clients' needs to be seen for issues quicker than an appointment is available. Additionally, a client may be referred out if an issue is outside of this provider's expertise. This action is not considered client abandonment and should not be deemed as such.

***Confidentiality***: Your relationship with this provider is important and confidential. Information cannot be released regarding your counseling without your written consent unless disclosure is required by state law. Examples of these are listed but not limited to:

1) Threatening harm or death to yourself (suicide).

2) Threatening harm or death to another person (homicide).
3) Abuse to a child or of the elderly or disabled.
4) Sexual exploitation (AIDS/HIV infection and possible transmission).
5) If a court of law issues a subpoena for notes/records.
6) If the therapy and/or evaluation is court ordered.
7) Fee disputes between the Therapist and the client.
8) A negligence suit brought by the client against the Therapist.
9) The filing of a complaint with the licensing or certifying board suspected child or elder abuse.

Part of providing quality care is respecting your privacy rights and maintaining confidentiality of all your records pertaining to therapy. This provider will not use or disclose your health information for any purpose not described in this notice without your written authorization.

If you are utilizing managed care benefits, please note information can and will be provided to the managed care provider. The managed care provider will need a diagnosis, which will be placed in your permanent medical record and also may put restrictions on treatment. It is for this reason that this provider is not part of most Managed Care plans. Being a solution-focused provider, my goal is to identify a problem, develop a plan of resolution and implement solutions to cope and increase a healthy quality of life. It is important that a client is aware that such labels and diagnosis may become a problem with different job requirements and clearances. Although one may not see themselves in a present life situation for these limitations, clients need to be aware that goals in life may change, which warrant a clean slate in their medical file.

# ***Consent to Treatment***

You do hereby seek and consent to take part in the confidential treatment by this provider. 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 have read understand and agree to Set Fees, Cancelation Policies, Counseling Relationship, Effects of Counseling, Defamation of Character, Relationship Outside of Counseling, Discontinuing Treatment, and Confidentiality Sections provided 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)

Therapist Signature_____

# 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? _____