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

<u>If you find yourself in an emergency situation, please call 911 or go to your nearest emergency room for immediate care.</u>

<u>Other Fees:</u>

*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 ***<u>DOES NOT</u>*** 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.

<u>Legal Fees:</u>

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. This will cover lost wages for rescheduled appointment.

Counseling Service Fees:
ADD/ADHD evaluation session $175.00. This type of evaluation is not covered by managed care benefits. It will be a fee for service session.
Individual 50-minute session is $170.00
Couples 50-minute session $180.00- Extended sessions charged in 15-minute increments
Couples 100- Minute Session $365.00
Family 50-minute session $190.00
Family Sessions 100-minutes session $320.00
Credit Card Cash backs or Declines $75

Late Cancellation, less than 24-hour or one business day notice $150
Missed Appointment charged at hourly rate
Payment for a missed appointment must be paid in full before rescheduling. A card on file will be used to pay the balance due.

*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***. ***Missed appointments will be charged at the hourly rate***. The credit card on file will be charged in the amount owed by the end of business day in which the session was scheduled. Please note you are initialing this section knowing your card will be charged. 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, HIPPA 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_____

NOTICE OF PRIVACY PRACTICES

Warner Family Counseling ,PLLC
THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
Warner Family Counseling PLLC 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 Warner Family Counseling, PLLC. or to the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. Warner Family Counseling, PLLC. will not retaliate against you in any way for filing a complaint with him, or with the Secretary.
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 Warner Family Counseling, PLLC, but you have certain rights to restrict some of the uses or disclosures of the information contained in your healthcare record Warner Family Counseling, PLLC.; 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 Warner Family Counseling, PLLC is required by law to maintain privacy and confidentiality of your health information, provide you with this Notice of Privacy Practices, notify you of your rights to restrict use of this information, notify you Warner Family Counseling, PLLC. is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this Notice. Examples of disclosure of your PHI and your rights concerning PHI are continued below.
EXAMPLES OF DISCLOSURE OF YOUR PHI
Healthcare delivery and treatment: Information obtained from you by Warner Family Counseling, PLLC is documented in your record and used for the assessment, evaluation, diagnosis and treatment of your health conditions). This information is provided to other healthcare professionals, such as other physicians, specialists, hospital-based providers and/or other healthcare providers following your treatment by Warner Family Counseling, PLLC. This information would only be provided to these individuals by your expressed consent.
Billing and Payment: Your PHI is utilized to justify the level of care delivered to you and the charged incurred for the services. This information generally accompanies the bill and is sent to our payers.
Other healthcare operations: Warner Family Counseling, PLLC, may disclose your PHI to other individuals and businesses in order for him to perform his day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for billing and claims management. These individuals are held to the same standard of privacy and confidentiality as Warner Family Counseling, PLLC.
Reminders and Treatment: Warner Family Counseling, PLLC may contact you to provide you with information she feels is useful or helpful to you, based on your PHI. For example, she may contact you to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.
Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Warner Family Counseling, PLLC has already taken action in reliance on your prior authorization. The only exception to this would be under circumstances that are life-threatening or an emergency, such as an individual being acutely suicidal or in some other way in extreme danger. Not all information provided by you to Warner Family Counseling, PLLC will be recorded in a healthcare record, only that information considered by her to be critical to providing for your care. Other information regarding personal matters in your private life and affairs will not be made part of a healthcare record document.
YOUR RIGHTS CONCERNING PHI - Except as otherwise provided by law, you have a right to:
• receive a paper copy of this Notice of Privacy Practices if you have agreed to receive it electronically;
• receive a confidential communications of PHI if a request is submitted to Warner Family Counseling, PLLC. in writing.
• inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set;
• ask Warner Family Counseling, PLLC. to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (Warner Family Counseling, PLLC. is not required to change the information if she deems it to be accurate);
• receive an accounting of disclosures of PHI (a list of the disclosures made by Tiffany Smith Counseling, Inc. about you for reasons other than treatment, payment or healthcare operations); and
• request that Warner Family Counseling, PLLC. restrict uses or disclosures of your PHI. Though Warner Family Counseling, PLLC. is not required to agree to a restriction, to the extent that it does agree with your request, Warner Family Counseling, PLLC. may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.
Effective Date: 01/10

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
Email Address: _____

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*

(rev. 5/23)

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 loses 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? _____

Client Credit Card Consent

The below credit card information, provided by the client or parent/guardian, will be placed on file. By signing this agreement, you are agreeing to allow Warner Family Counseling, PLLC to charge below listed credit card for any "no show, no call" appointments, late cancellations made inside of 24 hours of set appointment, and any telephone or ancillary charges (returned check fees, requested letter or documentation fees, any requested medical record copying fees).

Type of Credit Card (circle): Visa/ MasterCard
Name (as printed on card): _____
Credit Card Account Number: _____
Expiration Date: _____ 3 Digit Security Code/CVC: _____

Billing Address for Credit Card: _____

City_____ State_____ Zip_____

Email Address: _____ (to receive electronic copies of receipts)

By my signature below, I also request and provide Warner Family Counseling, PLLC my permission to charge the above listed account for ongoing regular therapy sessions according to the fee schedule, described in the General Policies and Client Consent forms, completed at time of admission/intake.

Printed Name: _____

Signature of Cardholder: _____

Date: _____