Silver Linings
Professional Counseling Services PLLC

Kara Kunz, MS, LPCC
silverliningsnky@gmail.com
71 Cavalier Blvd. Suite 325
Florence, Ky. 41042
p. 859-474-2777
f. 859-918-0909
www.silverliningsnky.com

Client Information and Consent

First_____ MI_____ Last_____

Address_____ City_____ ST_____ Zip_____

Home (____) _____ Work (____) _____ Cell (____) _____

email _____(used for billing purposes and correspondence only)

Okay to call or leave message at: Home? Yes No Work? Yes No

DOB_____ Age____ Gender Male Female

Emergency Contact_____ Phone (____) _____

Responsible Party Information: **FILL OUT ONLY IF SOMEONE ELSE IS PAYING FOR SERVICES**

First_____ MI_____
Last_____

Address_____ City_____ State _____Zip_____

Home (____) _____ Work (____) _____

Cell (____) _____

Relationship to Patient_____

Note: You will be responsible for costs associated with correspondents requested to be sent primary physicians, the courts, legal representative, etc. Cost for such services average is $25 per occurrence.

After reading each section, please initial that you have read and understood the information. Feel free to ask questions if something is not clear and do not hesitate to raise any concerns regarding this information with your therapist.

CONFIDENTIALITY

When seeking psychological services, you have the right to expect that issues discussed during the course of individual therapy will be kept confidential. Confidentiality means that your personal/private information will not be shared with others, since therapist/client communication is protected by law (Privileged).

There are times however, when we believe that exchanging or receiving important information from others (e.g., doctors, teachers, etc.) allows us to better serve your clinical needs and provide a higher quality of care. Therefore, with your agreement, you may waive the privilege of confidentiality by providing your written permission on a **Release of Information** form. Once you sign a release form, you may withdraw your consent at any time. Please read the Notice of Privacy Practices guide provided to you.

_____(Initial)

EXCEPTIONS TO CONFIDENTIALITY

There are several possible exceptions to confidentiality:

1. ***Danger to self and/or others:***

a. If there is reason to believe that you are a serious danger to yourself or others your therapist must take steps to reduce the risk.

2. Insurance reimbursement:

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A .If Insurance reimbursement is arranged, insurance companies reserve right to have another professional review the case. We are MANDATED by the insurance companies to give you a mental health diagnosis during the first session

b. Many insurers require periodic therapy summaries called outpatient treatment reports (OTR) before they will authorize additional treatment.

c. Information included on the insurance claim form is no longer considered confidential.

3. ***Court Orders***

a. There are cases where courts have ordered the release of otherwise privileged records, such as in certain child custody cases are judges have ruled that the well-being of the child outweighs the parent's privilege of confidentiality.

b. If you are involved in a criminal case, your records can be subpoenaed.

_____(initial)

APPOINTMENTS

Therapy appointments are typically scheduled for 50 minutes. You and your therapist will arrange the frequency of appointments that best suit your needs. Your insurance company may only allow for a specific number and frequency of appointments (e.g., every two weeks.) Should you wish to make a change in the frequency of appointments please discuss it with your therapist.

_____ (Initial)

CANCELLATIONS AND MISSED APPOINTMENTS

Cancellation of appointments will be accepted up to 24 hours prior to the time of the appointment without a fee incurred. Therefore, if you need to cancel or change your appointment for any reason please call to do so at the earliest possible time.

Since appointment times are held exclusively for you, late cancellations or missed appointments are lost time which might have been utilized by someone else. Therefore, cancellations with less than 24 hours prior notice to the appointment, or missed appointments, will be billed directly to you at $75 an occurrence, since insurance companies will not reimburse for same.

_____(Initial)

INSURANCE COVERAGE

If you have health insurance, part of your expenses may be covered. Please call your insurance by dialing the number on your insurance card to verify services covered. We will submit your insurance claims forms for you. Insurance coverage and limits must be verified by you prior to your first appointment **or you may be responsible for the cost of the session. Please see notice**

_____(Initial)

I understand the Office Policy Statements, limitations of treatment, and I authorize Kara Kunz, LPCC and or Associates of Silver Linings. to provide outpatient clinical counseling services.

Signature _____ Date _____

Notice of Privacy Practices Effective 12/01/2009

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

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We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect 12/1/09 **and will remain in effect until we replace it.**

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available on request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you with your consent.

Payment: We may use and disclose your health information to obtain payment for services provided to you with your consent.

Healthcare Operations: We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staff performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any other disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We may disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons involved in your care: We may use or disclose health information to notify or assist in notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required By Law: We may use or disclose your health information when we are required to do so by law such as in legal response to valid judicial, administrative subpoenas or court orders.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or

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law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may provide you with appointment reminders (such as voicemail messages, postcards or letters) unless you make a specific request to the contrary. (See alternative communication section 33)

Patient Rights

Access: You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We would use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first requests for copies. We will charge $.20 per page and $25 an hour for staff time and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied your request. In some circumstances, our denial of your request to inspect and receive copies of your information is not subject to review.

Disclosure Accounting: You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include disclosures made for treatment payment or healthcare operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization or disclosures made for law enforcement purposes. You may request one such record at no charge every twelve (12) months. The record requests must state the time desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to 12/1/09. **The first disclosure record requests a 12 month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any cost.**

Restriction: You have the right to request to place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. The request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternate the means or location of the request. We will make reasonable efforts to accommodate your request.

Amendment: You have the right to request that we correct your records if you believe information in your record is incorrect or important information is missing, by submitting a written request that provides the reason for requesting the amendment. We have the right to deny your request to amend the record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion the record is accurate.

Questions and Complaints: If you are concerned that we have violated your privacy rights, disagree with the decision made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the US Dept. of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint

Privacy Officer: Silver Linings Professional Counseling Services PLLC

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Phone (859) 474-2777 Fax (859)918-0909

Acknowledgement Form

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I acknowledge that I have received a copy of the Notice of Privacy Practices. The effective date of the notice is 12/01/2009.

Client's Name: _____

Date: _____

Signature of Client or Authorized Guardian: _____

Date: _____

Relationship of Authorized Guardian to Client: _____

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For Office Use Only We attempted to obtain written acknowledgment of receipt of the work notice of privacy practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited in obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

Other (specify)

_____

FEES AGREED IF PAYING OUT OF POCKET:

____ Patient does not have insurance or not covered by Silver Linings Professional Counseling Services, PLLC

____Patient refused to use insurance

I agree to pay $_____ per session

Client's initials_____ Date:_____

Therapist's initials_____ Date_____