CHRISTYKANE PhD

Client Rights

It is important for you to know you have many rights and responsibilities when you enter into counseling. The following list outlines them.

You have a right

- to considerate and respectful care, which includes freedom from any physical, sexual, fiduciary (financial), or psychological abuse including humiliating, threatening, and exploiting actions;
- to understand what your problem is, what treatment is recommended and why, who will give the treatment, and what outcome to expect;
- to be involved in a process of informed choice, informed refusal, and/or expression of choice related to preference of your treatment services, choice of service provider and participation in research projects;
- to expect that all communications and records pertaining to your care will be treated as confidential;
- to have continuity of care when you are referred for services outside this agency;
- to examine and receive an explanation of your bill.
- to participate in all aspects of your treatment, including development of your treatment plan.
- to have access to self-help and advocacy support services.
- to voice complaints or lodge an appeal without recrimination.
- to all legal protection and due process for status as an outpatient, both voluntary and involuntary, as defined under Utah law

Your responsibilities are

- to be honest in your presentation of your problems and to tell those working with you how you feel about what is happening to you.
- to be actively involved in the development of your treatment plan that will outline your problems, needs, goals, and expected outcome(s);
- to be considerate of others and their privacy;
- to present to your counselor any questions, complaints or concerns about your counseling plans or goals so that you may reach an agreement on any problem hindering your progress.

Client Name _____

Signature_____ Date_____

CONFIDENTIALITY AGREEMENT

please read and sign the following document prior to seeing a member of our treatment team

Confidentiality means that Dr. Christy Kane LLC has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your consent. In such situations, Dr. Christy Kane LLC is not required to inform you of their actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

Health Insurance Portability and Accountability Act (HIPAA):
Dr. Christy Kane LLC is required by law to protect the privacy of your health information. Although your counseling record is the physical property of Dr. Christy Kane LLC, the information contained in your health record belongs to you.

You have the right to:
- request a restriction on certain uses and disclosures of your information
- inspect and obtain a copy of your health record
- amend your health record as provided by regulation
- obtain an accounting of disclosures of your health information as provided by law
- request communications of your health care information by alternative means or locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

The Benefits of Counseling:

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family and other interpersonal relationships, and/or a greater understanding of personal goals and values.

The Risks of Counseling:

There are certain risks involved in counseling. You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. Further, counseling may not, by itself, resolve your concerns. Mental Health Professionals at Dr. Christy Kane LLC will do their best to assess progress and provide referrals to other sources if that is deemed necessary and appropriate. Psychotherapy is a collaborative process.The progress you make will depend largely upon your investment in the process.

Cost of Service:

1st visit evaluation is $175.00, then it is $150.00 per following session.

Payment of Fees:

All fees should be paid at the time the service is rendered. Cash, personal check, MasterCard, or Visa are welcome.Most insurance plans have an annual deductible, which must be met prior to reimbursement. If you have such a deductible, it is your responsibility to pay. Some insurance plans require the insured to call prior to the first visit and obtain authorization for a specified number of visits. If you fail to obtain this authorization prior to your initial psychotherapy session, you are responsible for payment.

Insurance Claims:

Please remember that you are responsible for payment of all fees whether or not your health insurance provides reimbursement.

Cancellations:

Cancellations must be made 48 hours in advance to avoid charge.
Missed appointments will be charged $100.00.
NSF CHECKS AND REJECTED CREDIT CARD CHARGES
There will be a $25 charge for each NSF check or credit card rejection.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING
I have read and accept this agreement and herewith consent to counseling with Dr. Christy Kane LLC.

Client Print Name _____ Date _____

Client Signature or Legal Representative _____

Dr. Christy Kane LLC Representative signature _____ Date _____

CHRISTYKANE PhD

PAYMENT AGREEMENT

Client Name		Date of Birth:	SS#
Responsible Party		Date of Birth:	SS#
Mailing Address			

I understand that I will be charged a fee for services received in accordance with the policies of Dr. Christy Kane LLC and the schedule below. I also understand that fees for all services are due at the time of service.

These fees are to be paid at the time service is received regardless of other payer sources*

$175.00	Per hour for Intake/Diagnostic Assessment (1st Visit)
$150.00	Per hour for Individual/Couples/Family Counseling
$58.00	Per hour for Group Session
$200.00	Per hour for Psychiatrist - Medication/Somatic Service (20 min is normal per visit)
$100.00	I also understand that there is a $100.00 charge for missed appointments or for appointments that are not canceled 48 hours in advance.
$100.00	Note: Anytime an appointment is scheduled credit card information is required for the purpose of charging co-pays, no shows, for appoints that are not cancelled 48 hours in advance, and to cover any balances not covered if insurances are billed.

I understand that certain insurance policies may pay a portion of the fees assessed for services received. I agree to provide copies of membership card(s) and claim forms when required. I understand that I am responsible for the amount not covered by my insurance up to the full fee for service. I also understand that I am still responsible for my Co-Pay amount to be paid at the time services are received. If the sum received through insurance and client fee payments exceeds the fee payments or the fee for service, the excess paid will be reimbursed to the client after all services, and claims for services, are processed.

Insurance Information

I certify that I am eligible for payment through the following resources. *Identification cards, etc. are to be provided upon request.*	
My insurance company is:	
Name of Insurance Holder	
Card Number	
Policy Number	
Contact Number for Insurance	
Contact Number for Policy Holder	

PAYMENT AGREEMENT

Release of Information/Assignment for Insurance Payments

I authorize payment of benefits directly to Dr. Christy Kane LLC for services rendered. I also authorize release of information (for insurance payment purposes only) that is protected by Federal Confidentiality rules (42 CFR, Part 2, Section 2.31 of PL-03-282).

The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

I also certify that I have read (or had read to me), understand, and have received a copy of Dr. Christy Kane LLC Services. fee policy, payment agreement, consent to treatment and confidentiality statement, Notice of Enrollment Disclosure, Notice of Privacy Practices and a copy of the Client Rights and Grievance Procedures. I understand that the Dr. Christy Kane LLC clinic does not discriminate against any individual based upon race, color, creed, sex, sexual orientation, national origin, religion, disability or economic situation including the ability to pay for services. Dr. Christy Kane LLC does not tolerate any form of harassment of clients or staff by any individual at any time. Dr. Christy Kane LLC is an equal opportunity employer and equal provider of services.

Credit Card Information Kept on file to bill for no-shows, co-pays, and services not covered by insurance and for self-pay clients

Credit Card Information	
Name On Card	
Card Number	
Expiration Date	
CV Code	
Address for Card	

Client Name: _____ *Date:* _____

Client Signature _____

Responsible Party Signature (if person served is under age 18) _____

FOR OFFICE USE ONLY

These documents have been reviewed, are filled out and complete.

Staff Member Name _____

Staff Signature _____ Date _____

DR. CHRISTY KANE LLC (DCK) INTAKE

Welcome, to Dr. Christy Kane LLC. Let's begin a healing journey with one of our mental health professionals and look forward to your future of empowerment.

Please print in legible, blue or black ink. Thank you!

Full Legal Name:
Cell Phone:
Home Phone:
Home Street Address:
City:
Zip code:
Emergency Contact Name:
Address:
Cell Number:
Work Phone Number:

Have you seen a mental health professional before? Yes ☐ No ☐	
What did you like about your therapy before?	
What did you *not* like about your therapy before?	
Who referred you to us?	
On a scale from 1 to 5, how motivated are you to change? 1 = I am not ready, and I do not think that change is even possible. 5= I am very confident I can change with the right person's help 1 2 3 4 5 6 7 8 9 10	

Client Signature _____ *Date* _____

Guardian Signature (if under age 18) _____

FOR OFFICE USE ONLY

These documents have been reviewed, are filled out and complete.

Staff Member Name _____

Staff Signature _____ Date _____

DR. CHRISTY KANE LLC (DCK) HEALTH FORM

Please complete all information on this form and bring it with you to your first visit.
It may seem long, but most questions only require a check, so it will go quickly.

Last Name:		**First Name:**	
Date of Birth:		Date:	
Primary Care Physician (PCP):		PCP Contact:	

You give permission for DCK to provide ongoing updates to your primary care physician? Y / N			
Client/Responsible party signature _____			
Have you seen a therapist/counselor before?	Yes ☐ No ☐	When? (dates)	
For what problem(s) are you seeking help?			
1)			
2)			
3)			
What are your treatment goals?			
1)			
2)			
3)			

Current Symptoms Checklist

Please list the symptom(s) you are currently experiencing

☐ Depressed mood	☐ Racing thoughts	☐ Excessive worry	☐ Unable to enjoy activities
☐ Impulsivity	☐ Avoidance	☐ Increased risky behavior	☐ Sleep pattern disturbance
☐ Hallucinations	☐ Loss of interest	☐ Increased libido	☐ Suspiciousness
☐ Concentration issues	☐ Forgetfullness	☐ Decreased libido	☐ Decreased need for sleep
☐ Excessive energy	☐ Increased Irritability	☐ Excessive guilt	☐ Fatigue
☐ Crying Spells	☐ Anxiety attacks	☐ Change in appetite	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Yes ☐ No ☐ If no, please skip to the next section. **If yes, please answer the following:**
Do you currently feel that you don't want to live? Yes ☐ No ☐
How often do you have these thoughts?:
When was the last time you had thoughts of dying?:
Has anything happened recently to make you feel this way?:
From 1 to 10, (10 being strongest) how strong is your desire to kill yourself currently? 1 2 3 4 5 6 7 8 9 10
Would anything make it better?:
Have you ever thought about how you would kill yourself?:
Is the method you would use readily available?:
Have you planned a time for this?:
Is there anything that would stop you from killing yourself?:
Do you feel hopeless and/or worthless?:
Have you ever tried to kill or harm yourself before?:
Do you have access to guns? If yes, please explain:

Personal and Family Medical History

Please indicate "self" for your conditions or indicate which family member (e.g. mother, brother, etc.)

Disease	Family Member	Disease	Family Member
☐ Thyroid Disease		☐ Anemia	
☐ Liver Disease		☐ Chronic Fatigue	
☐ Kidney Disease		☐ Diabetes	
☐ Asthma		☐ Stomach Problems	
☐ Respiratory Problems		☐ Intestinal Problems	
☐ Cancer		☐ Fibromyalgia	
☐ Heart Disease		☐ Epilepsy or Seizures	
☐ Chronic Pain		☐ High Blood Pressure	
☐ Head Trauma		☐ High Cholesterol	
☐		☐	

Medications & Medical History

List all current over-the-counter-medications, supplements and prescription medications. If none, write "none"

Height:		Weight:	
Allergies:			

Medication Name	Total Daily Dosage	Estimated Start Date

Current medical issues:			
Past medical issues, non-psychiatric hospitalization, or surgeries:			
Have you ever had an EKG? Yes ☐ No ☐	When?:		EKG was: Abnormal ☐ Normal ☐ Unknown ☐
Were there any complications with your birth?			
Did you have any childhood developmental issues?			
Do you have any concerns about your physical health that you would like to discuss with your provider? Yes ☐ No ☐			

For women only:

Date of last menstrual period:		
Are you currently pregnant or think you might be pregnant? Yes ☐ No ☐		
Are you taking birth control? Yes ☐ No ☐	If yes, what brand?:	

Exercise

Do you exercise regularly? Yes ☐ No ☐	
How many days per week?	
How many minutes per day of exercise?	
What kind of exercise do you do?	

How many caffeinated beverages do you drink per day?	Coffee _____	Energy Drinks _____	Soda _____	Tea _____

Psychiatric History

Have you received psychiatric outpatient treatment?	Yes ☐ No ☐	If yes, please describe below:

Reason	Date Treated	Where/by whom

Psychiatric hospitalization?	Yes ☐ No ☐	If yes, please describe below:

Reason	Date Hospitalized	Where

Past Psychiatric Medications

Under the "effect" column, list the side-effects and/or how helpful the medications were to you

Medication	Dates	Dosage	Effect

Family Psychiatric History

Medication	Dates	Dosage	Effect

Has anyone in your family been treated for or diagnosed with the following conditions?

☐ Bipolar Disorder	☐ Schizophrenia	☐ Post-traumatic Stress	☐ Depression
☐ Anxiety	☐ Alcohol Abuse	☐ Other Substance Abuse	☐ Other Addiction(s)
☐ Anger	☐ Suicide	☐ Borderline Personality	☐ Violence
☐ OCD	☐ Eating Disorder	☐ Narcissistic Personality	☐ Postpartum Depression

Has any family member been treated with a psychiatric medication? Yes ☐ No ☐

Please explain which family member experienced the condition listed above and if medications proved to be an effective treatment for them?

_____

_____

_____

_____

Substance Use

Think you may have a problem with alcohol or drug use?	Yes ☐ No ☐		
Have you been treated for alcohol or drug use or abuse?	Yes ☐ No ☐		
If yes, for which substance(s)?			
If yes, where were you treated and when?			
How many days per week do you drink any alcohol?			
Least number of drinks you will drink in a day?		Most number of drinks you will drink in a day?	
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?			

You feel you ought to reduce your drinking/drug use?	Yes ☐ No ☐	Feel bad/guilty about your use?	Yes ☐ No ☐
Have people annoyed you by criticizing your drinking and/or drug use?	Yes ☐ No ☐		
Have you ever had a drink/used drugs in the morning to steady your nerves or get rid of a hangover?	Yes ☐ No ☐		
Have you used any street drugs in the past 3 months?	Yes ☐ No ☐	Which?	
Have you ever abused prescription medication?	Yes ☐ No ☐	Which?	

Please indicate if you have used any of the following drugs

Drug	For how long & when did you last use?	Drug	For how long & when did you last use?
☐ Cocaine		☐ Methamphetamine	
☐ Heroin		☐ Stimulants (pills)	
☐ Marijuana		☐ LSD or Hallucinogens	
☐ Tranquilizer/sleeping pills		☐ Pain killers *(not as prescribed)*	
☐ Methadone		☐ Alcohol	
☐ Ectasy		☐ _____	

Have you ever smoked cigarettes?	Yes ☐ No ☐	Currently?	Yes ☐ No ☐
How many packs per day?		Since when?	
How long have you smoked?		Or When did you quit?	
Do you use pipe, cigars, or chewing tobacco currently?		Yes ☐ No ☐	

Relationship History

You are currently: Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐
How would you identify your sexual orientation?

Family Background & Childhood History

Were you adopted? Yes ☐ No ☐	Where did you grow up?
What was your father's occupation?	
What was your mother's occupation?	
How many siblings do you have?	What are their ages?
Did your parents divorce? Yes ☐ No ☐	If yes, how old were you when they divorced?
If yes, who did you live with after the divorce?	
Describe your father and your relationship with him: _____ _____ _____ _____	
Describe your mother and your relationship with her: _____ _____ _____ _____	
Has anyone in your immediate family died? Who? When?	

Trauma History

Do you have a history of being abused (emotionally, sexually, physically)? Yes ☐ No ☐ Do you have a history of being neglected? Yes ☐ No ☐
Please describe (when, where, by whom): _____ _____ _____ _____ _____

Education History

Highest educational level attained?	When?
Did you attend college? Yes ☐ No ☐	Where?
What was your major? (Or degrees held)	

Occupational History

You are currently: Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired ☐	
Have you served in the military? Yes ☐ No ☐	What branch, when?