KIMBERLY BOYD COUNSELING CENTER LLC

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Informed Consent and Practice Policies

Welcome to my practice and thank you for choosing to enter into a counseling relationship with Kimberly Boyd Counseling Center, LLC. This document contains important information about the professional services and business policies. When you sign this document, it will represent an agreement.

Counseling Process: Counseling is a collaborative and interactive process between the client and therapist. Being an active participant in the counseling process is strongly encouraged. Each client is an individual with unique characteristics that makes that person who they are.

Initially, counseling often results in the client experiencing uncomfortable feelings or thoughts. Because some issues are painful to deal with, there may be instances in which things seem to be more difficult before they get better. On the other hand, counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Together, we will develop the goals of your counseling sessions centered around your self-awareness, self-esteem, mental health, and independence. Client needs are unique; therefore, some clients need only a few counseling sessions to achieve their desired goals while other clients require months of counseling. As a client, you maintain control of yourself and you may end the counseling relationship at any point. When you are ready to terminate therapy, please allow at least one session so we can have closure.

Contact, other than chance meetings, will be limited to appointments you arrange with me. I will not attend your social gatherings or relate to you in any other way than in the professional context of our counseling sessions. You will be best served if our relationship remains strictly professional and our sessions concentrate exclusively on your concerns. Although you may learn about me as we work together, it is important for you to know that you are experiencing my professional role.

Fees: The initial session fee is $185.00. Follow up visits of 50 minutes are $150.00 and 45 minutes are $110.00. If you choose to utilize insurance or Medicaid benefits, you will be responsible for any deductibles, copayments, coinsurance or any variation thereof dictated and/or mandated by your insurance carrier.

*Cash rates for LPCs are $100.00 per individual session and $125.00 for marriage counseling. *Cash rates for LPC Interns are $45.00 for individual sessions and $65.00 for marriage counseling. Professional services include, but are not limited to, office appointments, therapeutic phone calls, third party consultations, written and verbal correspondence, and reports. *Phone consultations lasting 20 minutes or more will result in a session fee . *Evaluations/assessments may not be a covered treatment/procedure under your individual insurance plan; therefore, the entire cost will be due at the time of service. The full assessment fee is $750.00. Court costs require an initial payment of $500.00, then an additional $250.00 per hour for time at court. *Failure to provide 24 hour notice of appointment cancellation will result in a $90.00 fee. *Payment by cash, check, or credit card is due at the time of service. All checks are to be made out to Kimberly Boyd Counseling Center, LLC. *Returned checks will be charged an additional $25.00.

Request for Records: Requests for Records must be submitted in writing. Once the written request is received, acknowledgment will be given within 15 business days. The first 20 pages will incur a charge of $25.00. Each additional page is $.50. Documents requiring a Notary will incur an additional charge of $15.00.

Cancellations: Please provide 24-hour notice for cancellation and/or rescheduling of an appointment. Failure to provide 24-hour notice will result in a charge of $90.00. This fee can be charged to the credit card on file with Kimberly Boyd Counseling Center, LLC or paid by cash, check, or money order.

Insurance: If you are requesting that Kimberly Boyd Counseling Center, LLC bill your insurance, please fill out the Insurance Authorization and Release. You are responsible for all fees not covered or reimbursed by your insurance benefits, including but not limited to: deductibles, co-payments, co-insurance, missed appointments, late cancellations, correspondence/reports or services not approved by your plan. Any non-covered fees will be charged to the credit card on file. (See Financial Policy and Agreement) If the provider is not a provider for your insurance plan, you may have out-of-network benefits through your insurance company. If you have such benefits, I can provide you with a receipt that you may submit to your insurance so you can request reimbursement.

Contacting your clinician: Although therapists are not often immediately available by telephone, we make every effort to promptly respond to messages. Please leave an evening number since calls are often returned after hours. Because technical difficulties do sometimes occur, please call again if you have not received a return call by the end of the next business day. You may also send an email to Info@KimberlyBoyd.Net to request to be contacted by your therapist.

Emergency care: If you are experiencing an emergency and need to talk to someone immediately, call 911, a telephone crisis line or go to the nearest emergency room.

Privacy rights: Professional ethics and legal standards require that our conversation and my records (even the fact that you are a client) be kept confidential. However, under the following circumstances, I am legally and ethically obligated to breach confidentiality: (a) if you present a serious imminent danger to yourself or others (b) in cases of apparent neglect of a child, an elderly person, or a disabled person (c) when required by legal proceedings. If I must breach confidentiality, the minimum amount of information will be revealed – only enough to protect you or others.

If it is your child who is participating in psychotherapy/play therapy, please understand that the specific content of the sessions will remain confidential. General reports of your child's progress will be made to you and any information regarding danger to your child will be reported to you immediately.

We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. You are under the age of 18 years and are the victim of a crime.
7. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
8. You are a person over the age of 65 and your therapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
9. You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.
10. You file suit against your therapist for breach of duty or your therapist files suit against you.
11. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
12. You waive your rights to privilege or give consent to limited disclosure by your therapist.
13. Your insurance company paying for services has the right to review all records.

*If you have any questions about these limitations, please discuss them with your therapist.

Finally, if I want to consult with someone about the specifics of your case in order to better coordinate services (i.e. a doctor, school, attorney, or spouse); I will request that you sign a release of information. The signed release of information will be in effect for one year from the signature date unless otherwise noted.
Please review the *Policies and Practices to Protect the Privacy of Your Health Information* for a more extensive explanation of your privacy rights.

Complaints: If you have concerns or complaints regarding your treatment, please talk with me first or contact Kimberly Boyd Counseling Center, LLC 832.233.3086 or by emailing Info@KimberlyBoyd.Net. If there is not a resolution, you may contact: Texas State Board of Examiners of Professional Counselors 1100 West 49th Street Austin, Texas 78756-7111 or 512.458.7111

By signing these policies I,

(1) Acknowledge receipt of the *Policies and Practices to Protect the Privacy of Your Health Information.*
(2) Understand and agree to the stated practice policies as listed above and
(3) Give full consent for myself or my minor child, _____ to participate in psychotherapy. I certify that I have the legal right to seek and authorize treatment for myself or my minor child. I agree to inform the therapist of any changes in custody and inform any other guardians of the child's involvement in therapy.

_____ SIGN HERE _____

Client/Guardian Signature **Date**

_____

Print Name

_____

Minor Client's Printed Name

_____ _____ SIGN HERE _____

Legal Guardian's Printed Name **Legal Guardian's Signature** **Date**

Client Registration

Name: _____ SS#_____

Date of Birth: _____ Age: _____ Gender: Male_____ Female_____

Address:_____

City, State, Zip _____ Email:_____

Employer/School: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Where do you prefer to receive calls? Home_____ Work_____ Cell_____

Emergency Contact Name and relation:_____

Address: _____Phone: _____

Individuals who live in the home:

Name	Age	Relationship

Health Information:

Please list any medical conditions you feel the therapist should be aware of:

_____

_____

Please list all medications you/client are currently taking, including the dosage:

_____

_____

Please list any known allergies: _____

Name and phone number of Primary Care Physician: _____

Permission to contact Physician? _____yes _____no

Have you ever seen a mental health provider? _____yes _____no

If yes, who and when: _____

Current legal proceedings? _____yes _____no Military Service: _____Active _____Former _____Branch

What are your goals for therapy**:**

_____

_____

_____

Developmental History of Clients Under Age 18:

Parent/Guardian Name:_____

Address (if different): _____

Phone number: _____ Cell: _____

Parent/Guardian Name:_____

Address (if different): _____

Phone Number: _____ Cell: _____

What languages are spoken at home?_____

How many years were parents married before birth or adoption of child? _____

In what year were the parents separated, if applicable? _____ Who has legal custody: _____

Are **you** authorized to seek counseling for this child? ____Yes ____No

What was child's birth weight? _____ Were eating/sleeping patterns __regular __irregular?

What was child's approach to new situations: __Positive __Withdrawn __Slow to warm up?

What was child's reaction to new stimuli: __Intense __Moderate __Little or None?

When trying new things or encountering new situations, regardless of your child's initial reaction, would you describe your child as __Adaptable __Slow to adapt __Unadaptable

Your child's activity level would be described as: __Extreme __Moderate __Quiet

What age was toilet training started? _____ What age was it established? _____ Describe any struggles, if any, with toilet training:_____

Does the child ever wet the bed? __Yes __No How often?_____

Does the child wet primarily during the __Night __Day __Both? Does the child ever soil? __Yes __No. Where is child usually when soiling or wetting occurs? _____

How is discipline handled in the home? _____

_____

Describe any traumatic events that child has been through (deaths, abuse, moves, etc.)_____

_____

List child's interests/hobbies/skills: _____

Please list any additional information which you think the therapist should be aware:_____

_____

_____

_____

Insurance Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ SIGN HERE _____

Signature of Client or Guardian **Date**

Primary Insurance:

Name of Insured: _____Insured's Birthday: _____

Insured's Address: _____

City, State, Zip _____

Phone: _____Relationship to client: _____

Employer: _____Insured SS #: _____

Insurance Company _____ID & Group#:_____

Insurance Phone #: _____

Client Name: _____

Client's Birthday: _____Cient SS #:_____

Financial Policy and Agreement

Cancellation

If cancellation is less than 24 hours in advance of your appointment, you will be charged the full appointment fee. Initial appointment fee is $110.00 and the follow up appointment fee is $90.00.

I authorize Kimberly Boyd Counseling Center to charge my credit card listed below, which will be kept on file the full appointment fee. _____ **Initial Here**

INITIAL HERE

Insurance

Any fees not covered by your insurance company will be charged to your credit card on file. Fees include but are not limited to copayments and insurance deductibles.

I authorize Kimberly Boyd Counseling Center to charge my credit card listed below, which will be kept on file, any amounts not covered by my insurance company including but not limited to copayments and insurance deductibles. _____**Initial Here**

By signing below, I acknowledge and agree to the Financial Policy and Agreement. I further instruct my credit card issuer to honor any charges subject to the Financial Policy and Agreement.

INITIAL HERE

_____ SIGN HERE _____

Signature of Client or Guardian **Date**

Please provide the following information:

Name on Card _____ Visa ___ MasterCard ___ Discover___ Amex___

Credit Card Number _____ Exp Date _____ Sec Code _____

Billing Address _____ City _____ State _____ Zip _____

Kimberly Boyd Counseling Center, LLC

Patient Consent for Use of Email Communications

Kimberly Boyd Counseling Center, LLC has established an e-mail address for some forms of communication. For routine matters that do not require immediate response, please feel free to email the office at **Info@KimberlyBoyd.Net**. You may also email your therapist directly. Remember however, this form of communication:

- Is not appropriate for use in an emergency
- Is a means of communication, but not a therapeutic venue

The turnaround time for routine client communication is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this means of communication is not appropriate.**

When sending an email to Info@KimberlyBoyd.net, please

- Put your therapist's name in the subject line so it can be processed efficiently.
- Put your name and return telephone number in the body of the message.
- Use the auto reply feature to acknowledge receipt of emails coming from this office.

When sending an email directly to your therapist, please

- Put the subject of your message in the subject line.
- Put your name and return telephone number in the body of the message.
- Use the auto reply feature to acknowledge receipt of emails from your therapist.

Communications relating to diagnosis and treatment will be filed in your chart.

Despite best efforts, due to the nature of email, third parties may have access to messages. All emails are maintained in the logs of your and/or our internet service providers. While under normal circumstances no one accesses these logs, they are, in theory, available to read by the system administrator(s) of the internet service provider. Additionally, when communication from work, please be aware that some companies consider email corporate property and your email messages may be monitored.

I understand that Kimberly Boyd Counseling Center, LLC and all Associates will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond control. I understand and agree to the above email policy.

By signing below, I am agreeing that Kimberly Boyd Counseling Center, LLC and all Associates may send correspondence to me via email, and may receive and respond to my emails via email.

_____ SIGN HERE _____

Signature of Client or Guardian **Date**

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

36-item version, self-administered

Patient Name: _____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Date:**_____

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include **diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.** Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only **one** response.

							Clinician Use Only		
Numeric scores assigned to each of the items:		1	2	3	4	5	Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did you have in:									
Understanding and communicating									
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 30	____ 5
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.3	Analyzing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do			
Getting around									
D2.1	Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 25	____ 5
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.5	Walking a long distance, such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do			
Self-care									
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 20	____ 5
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do			
Getting along with people									
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 25	____ 5
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do			

							Clinician Use Only		
Numeric scores assigned to each of the items:		1	2	3	4	5	Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did you have in:									
Life activities—Household									
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 20	____ 5
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.3	Getting all of the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do			
Life activities—School/Work									
If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.									
Because of your health condition, in the past 30 days, how much difficulty did you have in:									
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 20	____ 5
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.7	Getting all of the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do			
Participation in society									
In the past 30 days:									
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do		____ 40	____ 5
D6.2	How much of a problem did you have because of barriers or hindrances around you?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.4	How much time did you spend on your health condition or its consequences?	None	Some	Moderate	A Lot	Extreme or cannot do			
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do			
						General Disability Score (Total):		____ 180	____ 5