ELISE BENNETT, MS, LMFT

4444 N Belleview, Suite 211, Kansas City, MO 64116
*Phone: 816-343-4356 * Fax: 816-407-7706*
elisebtherapy@gmail.com

Date: _____

CLIENT INTAKE INFORMATION AND INFORMED CONSENT

_____
Client Name Address City State Zip

_____ ☐ May Call ☐ May Leave a Voicemail ☐ May Text
Cell Phone Number

_____ ☐ May Call ☐ May Leave a Voicemail ☐ May Text
Alternate Phone Number

_____
Contact Email Address

M / F
Client Date of Birth Marital Status Sex

_____
Client Employer and Occupation Address City, State, Zip

_____
Spouse's Name Spouse's Employer/Occupation Spouse's Cell #

Referred to this Clinic By: _____

COORDINATION OF CARE:

_____
Primary Care Physician Address Phone #

_____
Psychiatrist Address Phone #

To coordinate among providers so that I may receive the most complete and accurate care possible, I give permission for my therapist to contact the above listed clinicians. I understand that no information, other than the fact that I am receiving treatment, will be shared without a signed Release of Information from me.

_____
Client Signature/Responsibility Party Date

EMERGENCY CONTACT:

_____
Name of a local friend or relative Relationship to Client Phone Number

AUTHORIZATION TO TREAT:

I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my, or my child's scheduled appointments and understand that failure to do so more than two times may result in my care being terminated.

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it.

_____ _____

Client Signature Date Client Signature Date

AUTHORIZATION TO TREAT MINOR CHILD:

Name of Child _____ DOB: _____

Name of Child _____ DOB: _____

Name of Child _____ DOB: _____

I warrant that I am a custodial parent of the above named minor child/children. I hereby give permission for him/her to receive counseling. I acknowledge that I am aware of the mandating reporting laws in the state of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my child.

_____ _____

Primary Custodian/Guardian Signature Date Primary Custodian/Guardian Signature Date

PERSONAL HEALTH HISTORY

List any medical or physical problems, hospitalizations, and surgeries; include when they were diagnosed

List all prescription and over-the-counter drugs you are taking:	**Any Allergies:**

PRIMARY REASON (S) FOR SEEKING SERVICES

☐ Anger Management/ Aggression	☐ School/ Learning/ Developmental Issues	☐ Work/ Employment Issues
☐ Anxiety/ Fears/ Phobias	☐ Grief/ Loss	☐ Weight/ Eating Disorders
☐ Depression/ Mood Problems	☐ Family/ Marriage/ Relationship Issues	☐ Suicidal Thoughts/ Hurting Self
☐ Sleeping Problems	☐ Parenting/ Behavioral Problems	☐ Homicidal Thoughts/ Harming Others
☐ Trauma	☐ Sexual Concerns	☐ Gambling issues
☐ Alcohol/ Drugs/ Addictive Behaviors	☐ Mental Confusion/ Psychosis	☐ Other Concerns

FINANCIAL POLICIES:

1. **Cash Session Fee:** A 55-minute session fee is $115.00.
   You may pay regular session fees by cash, check (payable to Elise Bennett LLC), or debit or credit card. We do require you to keep a debit or credit card on file, even if you do not use it for regular session fees. Appointment times are typically set at the end of the current appointment or via email.

2. **Session Fee if filing Insurance:** $115.00
   Insurance can be filed out–of-network for most insurance companies. The full session fee is required at the time of service until a co-pay is negotiated with your insurance company or an out-of-network deductible is met. Our billing service will file the insurance claim for you. The reimbursement portion will be sent to our office and will be credited to your account. We will need a copy of the front and back of your insurance card.

   _____
   Full Name of Insured Address City, State, Zip

   _____
   Relationship to Client SS# Date of Birth

   _____
   Insurance Company Address City, State, Zip

   _____
   ID# Group # Employer

   I herby authorize Elise Bennett to release any information acquired in the course of my treatment or examination to my insurance company for billing purposes only.

   _____
   Signature Date

3. **Payment Method:** Cash, checks, or Credit Cards are all accepted. Checks can be made payable to ELISE BENNETT LLC. All debit card and credit card information is kept secretly on file. (NOTE: A $25.00 fee will be added to your account for each check that is returned).

   Credit Card Information is Required to be kept on file. Overdue expenses past 30 days will be charged to the card on file.

   Name on Card: _____ Exp. Date: _____ Billing Zip: _____

   Card #: _____ Check One: M/C _____ Visa _____

   I would like to pay my regular session fees with the above debit/credit card. _____ Yes _____ No

4. **Late Cancellations and Missed Appointments:** The first time you miss or cancel a session with less than 24 hours notice, there will be no penalty. The second time, you will be charged 50% of your session fee. On the third and any future late cancellations and/or missed appointments, will be charged the full session fee.

5. **Communication via Phone and Email**: Phone calls and e-mails to or from you, or on your behalf that are over 10 minutes long may be charged to you at a prorated portion of your session fee, i.e. 15 minutes = ¼ charge of your regular session fee. This excludes communication about setting up future session times. These particular fees will be charged directly to the card on file.

6. **Account Balances over 60 days:** Account balances over 60 days will incur a finance charge of $15.00 per month. If there are unpaid balances over 120 days, those accounts are subject to being turned over to a collection agency or attorney.

7. **Reports and Court:** If a report for court is requested, there will be a charge for the preparation of the report based on the time required to prepare the report. There are separate fees for testifying in court or for depositions, as follows:
   - *FMLA/Letters to physicians, employers, schools $40.00*
   - *Court Testimony (includes all required time to prepare, note preparation, travel to/from court, and appear in court) $200.00/hour.*

   These particular fees are not able to be filed with your insurance. A $400 deposit is required prior to testimony date in order for the clinician to appear.

RESPONSIBLE PARTY (if other than client):

_____

Name Address City State Zip

_____

Relationship to Client SSN# DOB Alternate Phone #

PLEASE SIGN THE FOLLOWING FINANCIAL STATEMENT:

My signature below indicates that I understand and agree with the above financial policies. I understand that I am financially responsible for the full fee at the time services are rendered. I authorize treatment by this office.

_____

Clint Signature/Responsible Party Date

ELISE BENNETT, MS, LMFT
4444 N Belleview, Suite 211, Kansas City, MO 64116
*785-341-2977 * elisebtherapy@gmail.com*

CLIENT RIGHTS

YOU HAVE THE RIGHT:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action
9. To end therapy at any time without moral, legal or financial obligation other than those already accrued.

CONFIDENTIALITY OF INFORMATION:

Laws ensuring your right to privacy protects matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is known or suspected (reporting is required by law)
2. When the abuse of an elderly or depended person is known or suspected (required by law)
3. If you commit a crime against a staff member of another person in the premises,
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.

SECURITY OF RECORDS:

Your treatment of record related and related financial records are kept in a locked file cabinet. Records will not be made available to others without signed authorization to release information and payment for the records prior to releasing them. Special rules relating to the release of treatment records containing information regarding drug and alcohol abuse: CFR 42, PART 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. This information cannot be disclosed to another source without written consent. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation/prosecution is strictly prohibited.

RETENTION OF RECORDS:

Treatment records are retained for a period of seven years following the termination of treatment for adults and until ages 28 in the case of minors. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

INFORMATION REGARDING PSYCHOTHERAPY:

Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well-being may also occur. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client's psychological functioning. Psychotherapy has been shown effective in about 75% of cases. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.

ADDITIONAL INFORMATION REGARDING THERAPY:

1. I understand the therapist provides therapy to individuals, couples, and families from a systems perspective utilizing therapeutic approaches/models associated with the marriage and family therapy profession.
2. I understand that the therapist is/are bound by the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT) and that I can request a copy of those ethics at any time.
3. I understand the risks and benefits associated with therapy and have discussed those with the therapist.
4. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; we will make these recommendations if they are appropriate, based upon our assessment.
5. I understand that I may leave therapy at any time.
6. I understand if there is no session activity or phone contact recorded in my file for a period of 3 weeks and I do not respond to my therapist's attempts to make contact with me, my file will automatically be closed. I understand that, in most circumstances, my file can be re-opened upon completion of a new intake and payment of any balance due.

_____ _____

Client Signature Date Client Signature Date

Elise Bennett, LLC
NOTICE OF PRIVACY PRACTICES

HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is "Medical Information"?

The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan, or others and relates to the past, present, or future physical or mental health or condition of an individual (you); the provision of health care (e.g., mental health) to an individual (you); or the past, present, or future payment for the provision of health care to an individual (you). Elise Bennett is a Licensed Clinical Marriage and Family Therapist in the State of Missouri. Elise creates and maintains treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records," and this notice, among other things, concerns the privacy and confidentiality of those records and the information contained therein.

Uses and Disclosures Without Your Authorization

For Treatment, Payment, or Health Care Operations Federal privacy rules (regulations) allow health care providers who have a direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. Elise may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

An example of a use or disclosure for treatment purposes: If Elise decides to consult with another licensed health care provider about your condition, she would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist him in the diagnosis or treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. because physicians and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another. An example of a use or disclosure for payment purposes: If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, Elise is permitted to use and disclose your personal health information. An example of a use or disclosure for health care operations purposes: If your health plan decides to audit my practice in order to review my competence and my performance, the competence and performance of Elise, or to detect possible fraud or abuse, your mental health records may be used or disclosed for those purposes .PLEASE NOTE: Elise or someone else in my practice acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Other Uses and Disclosures Without Your Authorization:

I may be required or permitted to disclose your personal health information (e.g., your mental health records) without your written authorization. The following circumstances are examples of when such disclosures may or will be made:

1) If disclosure is compelled by a court pursuant to an order of that court
2) If disclosure is compelled by a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority
3) If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.
4) If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.
5) If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
6) If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.
7) If disclosure is compelled by the patient or the patient's representative.
8) If disclosure is compelled or by the Child Abuse and Neglect Reporting Act (ie: if I have a reasonable suspicion of child abuse or neglect).
9) If I have a reasonable suspicion of elder abuse or dependent adult abuse.
10) If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
11) If disclosure is compelled or permitted by the fact that you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.
12) If disclosure is compelled or permitted, in the event of your death, to the coroner in order to determine the cause of your death.
13) As indicated above, I am permitted to contact you without your prior authorization to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you. Be sure to let me know where and by what means (e.g., telephone, letter, email, fax) you may be contacted.
14) If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, including but limited to, audits, criminal or civil investigations, or licensure or disciplinary actions. If disclosure is compelled by the U. S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule").
15) If disclosure is otherwise specifically required by law.

I have read and understand the above HIPAA regulations.

_____ _____

Client Signature/Responsible Party Date Client Signature/Responsible Party Date