Keystone Counseling

11650 Lantern Rd, Suite 125
Fishers, IN 46038
Ph. 317.833.9160
info@keystoneindy.com

New Client Information Form

Client (1) Information

Last Name: ________________________ First Name: ________________________ MI: ________

Date of Birth: _______________ Age: _______ Gender: ______ Relationship Status: __________

Address: ____

City, State, Zip: ____

Cell Phone: _______________________________ May we contact you at this number? __Yes __No

Email address: _________________________________ May we contact you by email? __Yes __ No

Client (2) Information

Last Name: ________________________ First Name: ________________________ MI: ________

Date of Birth: _______________ Age: _______ Gender: ______ Relationship Status: __________

Address: ____

City, State, Zip: ____

Cell Phone: _______________________________ May we contact you at this number? __Yes __No

Email address: _________________________________ May we contact you by email? __Yes __ No

Permission for Treatment

In presenting myself for diagnosis and treatment, I voluntarily consent to the rendering of counseling services provided by Keystone Counseling LLC. I acknowledge no guarantees have been made to me as to the effect of treatment on my condition or relationship. I acknowledge I am responsible for all reasonable charges in connection with care and treatment. I have read this statement and acknowledge that I understand it.

____ ___________________________

Client (1) Signature Date

____ ___________________________

Client (2) Signature Date

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Policy Statement Regarding Fees

- The cost of each session is $85.00 for 50 minutes and is billed directly to the client. Sessions begin at the designated appointment time and are 50 minutes in length.

- Payment is due at the time of each session by either filling out the provided credit card form, or paying with check or cash. If email is provided on the new client information form, a receipt will be provided via email for the client to make their own insurance claim.

- Clients will be charged $30 for returned checks. Upon the occurrence of a returned check the client will be required to pay by cash or credit card for future sessions.

- A No Call / No Show is defined by either a client missing an appointment without prior notice, or arriving more than 15 minutes after the designated appointment time without notifying the office via email or phone. All No Call / No Show's will be billed directly to the client for the full fee of $85 for the scheduled session.

- A late cancellation is any cancellation notice given within 24 hours of the designated appointment time. Late cancellations will be billed directly to the client at the rate of $40.00 per occurrence.

- We do our best to avoid engaging in any client legal matters such as custody disputes or divorce proceedings. However, if legally compelled to do so, court time or consultations with third parties (NOT related to billing or treatment coordination) will be billed directly to the client at the rate of $100.00 per hour with a $50.00 minimum.

- Time spent preparing letters, misc. paperwork, court documents etc. on behalf of a client will be billed directly to the client at the rate of $50.00 per hour with a $25.00 minimum.

- Therapeutic discussions via phone or email are discouraged, as we value face to face connections between a client and therapist as part of the therapy process. However, if you feel you must discuss a matter prior to your next appointment, you may e-mail or phone the office. Therapy via telephone will be billed directly to the client at the same rate as an in office session of $85.00 for 50 minutes.

By signing below, I attest that I have read and fully understand this Policy Statement, and that I agree to pay any charges that may be applied to my account as a result of these policies.

____ _______________________

Client (1) Signature Date

____ _______________________

Client (2) Signature Date

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Credit Card Authorization Form

I, ____ , hereby authorize Keystone Counseling LLC to charge my credit card account according to the following fee schedule: $85 for each 50 minute counseling session and $42.50 for each additional 25 minutes, $85 for each No Call / No Show fee, and $40 for each Late Cancel fee.

( ) VISA ( ) MasterCard ( ) American Express ( ) Discover

Credit Card Number: ____

Expiration Date: _____ /______

Credit Card Billing Address:

Name as it appears on card: ____

Address (if different than Client Info form):

Street: ____

City:____ State: ______________

Zip Code: ____________ - __________

Telephone: (____) _____- __________

By signing below, I authorize the charges specified above.

____ _________________

Cardholder's Signature Date

Your completion of this authorization form helps us to protect you from credit card fraud. Keystone Counseling LLC will keep all information entered on this form strictly confidential and in a secure location.

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Privacy Practices and Company Policies

Keystone Counseling LLC includes the treating therapists, the supervising therapist, the business manager, and business associates. We are committed to your privacy and we will follow the terms of this Notice. If you have any questions about this Notice of Privacy Practices, please ask the supervising therapist at Keystone Counseling LLC via email at info@keystoneindy.com or phone (317) 833-9160.

How we may use and share information about you:

Contacting you: We may contact you by mail, phone, or email regarding appointments, payment, follow up of treatment, to ask about the quality of services provided you, or to make you aware of new products or services Keystone Counseling offers.

Treatment plans/notes: We will produce notes regarding your treatment. These constitute Keystone Counseling's clinical and business records, which we must legally maintain and they are the sole property of Keystone Counseling. Should you desire your notes be provided to a fellow health care professional, the request must be completed in writing via an information release form. For example, if you are being treated for depression by a psychiatrist, it is important for your doctor to be informed of your therapy goals, etc., for your physical well-being and treatment goals. Keystone Counseling will keep your records for 7 years after termination of therapy at which time they will be destroyed in a confidentiality preserving manner.

Client litigation: Keystone Counseling will not voluntarily participate in any litigation or custody dispute in which you or anyone else are parties. Keystone Counseling has a policy of not communicating with attorneys regarding confidential information and will generally not write or sign letters, reports, or declarations to be used in any legal matter, and generally will not provide records or testimony unless compelled to do so. The information disclosed in sessions and any records created are subject to the therapist-client privilege, similar to the doctor-patient privilege.

Insurance reimbursement: You are responsible for all fees. Keystone Counseling does not bill insurance for payment. Keystone Counseling will provide a receipt of service, via email if supplied, for you to submit to insurance for reimbursement if you so desire. Please, be aware the insurance company will require diagnosis, dates of service, and treatment method. Confidentiality is waived if you choose to submit this information to an insurance company.

Involved third parties: You have the option of involving family members or friends in your treatment process or payment for care. When this is the case, we will share sales receipts or scheduled appointments, but session information will not be discussed. In emergencies or situations in which you are unable to tell us who to share information with, we will only share information that others need to know. For example, if you express a plan to harm yourself, it is standard practice to inform a trusted family member or friend to be involved in your safety plan. We may also share information about you with a public or private agency during a disaster so the agency can help contact your family or friends about your location and tell them how you are doing.

Therapist availability: Keystone Counseling is unable to provide 24-hour crisis service. We recommend that if you are feeling unsafe or need immediate medical or psychiatric evaluation you call 911, 317-251-7575, or go to your nearest emergency room.

Threats to health or safety: When necessary to prevent a serious and urgent threat to the health and safety of you or someone else, we will share your personal information with appropriate authorities such as the

police or DCS. This includes if we learn about possible abuse or neglect of children, elders, or dependent adults, as well as if we believe a client has been the victim of abuse, neglect, or domestic violence.
Law enforcement: We may release your personal information to a law enforcement official, as authorized or required by law: in response to a court order, subpoena, warrant, summons or similar process; if you are suspected to be a victim of a crime, generally with your permission; about a death we believe may be the result of a crime; about criminal conduct within the practice; in an emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Professional consultation: Professional consultation is an important component of a healthy therapy practice. Our therapists regularly participate in clinical/ethical/legal consultation with appropriate professionals. In such consultations our therapists WILL NOT reveal any personally identifying information regarding our clients.

Video/Audio recording: Occasionally, we request to make an audio or video recording of a therapy session for consultation, training or supervision purposes. You are under no obligation to consent to the recording without penalty or consequence. Benefits of allowing recording include case consultation with other skilled therapists who may provide helpful insight regarding therapy interventions and progress. We take several precautions to protect your confidentiality including using a digital camera, only using a password protected computer to view the recording, as well as deleting the recording after completion of supervisory review of the session. Consent will be obtained prior to each recorded session and you have the right to withdraw your consent at any point by verbal or written notice.

Termination of therapy: Keystone Counseling reserves the right to terminate therapy at the therapists' discretion, for reasons including, but not limited to untimely fee payment, noncompliance with treatment recommendations, conflict of interest, failure to participate in therapy, or your needs are outside the therapist's scope of practice or competence. You have the right to terminate therapy at your discretion with the appropriate notice to cancel all further sessions in order not to accumulate fees for late cancels or no call/no shows.

Changes to this notice: We have the right to change this Notice at any time. Any change could apply to personal information we already have about you as well as any information we receive in the future. We will maintain a copy of the most current notice on the website and in the office.

Acknowledgment:
By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Notice. You agree to abide by the terms and conditions and consent to participate in therapy with Keystone Counseling. Moreover, you agree to hold Keystone Counseling (the treating therapist, supervising therapist, and business manager) free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

____ _______________________

Client (1) Signature Date

____ _______________________

Client (2) Signature Date

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Audio/Video Recording for Consultation/Training Consent Form

In order to continually improve our therapy, interventions, and professionalism, we like to record our therapy sessions from time to time for the purpose of consultation, further training, and supervision. No names or identifying information other than what is on the recording will be released to anyone. You are free to say no without any penalty or consequence. If at any time you change your mind, after giving consent, we can stop the recording.

This is to confirm that I give my consent to Keystone Counseling, LLC, to audio/videotape our counseling session for the purpose of supervision, consultation, and training. I further understand and agree that these recordings may be reviewed with supervisors at or for Keystone Counseling and that these recordings will be erased immediately following such reviews to safeguard the confidentiality of these counseling sessions.

____ _______________________

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Self Assessment

In filling out this form you are welcome to provide as much or as little information as you would like. Your therapist will review this form and if they have any questions regarding your answers, they will follow up with you in session.

Section A: Client Information

Client Name: ____________________________________ Date of Assessment: ________________

Date of Birth: ___________________________________ Age: ______ Gender: ______

Relationship Status: ______________________________ Ethnicity: __________________________

Are there cultural or heritage influences that are important to you of which your counselor should be aware?

Yes or No If yes, please explain: ____

Are there religious or spiritual beliefs that are important to you of which your counselor should be aware?

Yes or No If yes, please explain: ____

Are there sexual orientation matters or concerns that are important to you or that you would like to discuss which your counselor should be aware? Yes or No

If yes, please explain: ____

Section B: Presenting Problem

Briefly describe the problem or concern you are currently experiencing.

____

____

Approximately how long have you had the current problem or concern? ______________________________

In what ways have you attempted to cope with this problem or concern?

____

____

____

What do you hope to accomplish through counseling?

____

____

Section C: Family Background

Please list the members of your family.

a. Father Age: Occupation: Education:

b. Mother Age: Occupation: Education:

c. Sibling Age: Occupation: Gender:

d. Sibling Age: Occupation: Gender:

e. Sibling Age: Occupation: Gender:

f. Sibling Age: Occupation: Gender:

What is/was your parents' marital status? ____________________

Any deaths in your immediate family? Who and when? ____

Please list your step-family members. (please circle "step" or "half")

a. Step-father Age: Occupation: Education:

b. Step-mother Age: Occupation: Education:

c. Step/half sib Age: Occupation: Education:

d. Step/half sib Age: Occupation: Education:

e. Step/half sib Age: Occupation: Education:

f. Step/half sib Age: Occupation: Education:

What is your spouse's/partner's Name: ____________________________________ Age: __________

Occupation: ____________________________ Highest Education Level: _____________________

Deceased: Y or N Year: ___________________

Please list any children of yours.

a. Child one Age: Adopted: Y or N Gender: M or F

b. Child two Age: Adopted: Y or N Gender: M or F

c. Child three Age: Adopted: Y or N Gender: M or F

d. Child four Age: Adopted: Y or N Gender: M or F

e. Child five Age: Adopted: Y or N Gender: M or F

Please list any step-children of yours.

a. Step-child one Age: Gender: M or F

b. Step-child two Age: Gender: M or F

c. Step-child three Age: Gender: M or F

d. Step-child four Age: Gender: M or F

e. Step-child five Age: Gender: M or F

Section E: Education and Work Information

What is your highest education level? ____

If college or above what was your major/minor/area of concentration?_________________________

Did you experience any learning problems in school? Yes or No

If yes, please explain:____

What is your current job and/or occupation? ____

Where are you employed?____

How satisfied are you with your current job and/or occupation? (please circle a word below)

Very satisfied Satisfied Neutral Dissatisfied Very dissatisfied

Section F: Health History

How is your physical health at present? (please circle a word below)

Poor Fair Satisfactory Good Excellent

Please list any persistent physical symptoms or health concerns (ex: chronic pain, headaches, etc.)

____

____

____

Please list any prescribed medications you are presently taking, including dosage and frequency

____

____

____

____

Are you having any problems with your sleep habits? Yes or No

If yes, please explain: ____

How many times per week do you exercise? ____________________ For how long? ________________

Are you having any difficulty with appetite or eating habits? Yes or No

If yes, please explain: ____

Have you had a significant weight change in the past two months? Yes or No

If yes, please explain: ____

Do you have any problems or worries about sexual functioning? Yes or No

If yes, please explain: ____

Do you regularly use alcohol? Yes or No

In a typical month, how often do you have four or more drinks in a 24 hour period? ______________________

Have you ever tried to cut down on the amount of alcohol you consume? Yes or No

Has anyone close to you ever been annoyed by your drinking? Yes or No

Do you consider your alcohol consumption to be a problem? Yes or No

How often do you engage in recreational drug use? ____

Do you consider this drug use to be a problem? Yes or No

Have you ever experienced legal problems? Yes or No

If yes, please explain: ____

Section G: Mental Health History

Are you currently receiving psychiatric services or professional counseling elsewhere? Yes or No

If yes, by whom? ____

Have you ever had previous counseling services? Yes or No If yes, please provide the following:

Reason for counseling: _____________________________ Dates: ______________________

Name of Organization or Professional: ____

Have you ever been hospitalized for psychiatric reasons? Yes or No If yes, please specify the following:

Reason for hospitalization: ___________________________ Dates: ______________________

Name of hospital and location: ____

Have you had suicidal thoughts recently? Yes or No If yes, how often? ___________________________

Have you had them in the past? Yes or No If yes, how often? ___________________________________

Have you ever intentionally inflicted harm upon yourself? Yes or No

If yes, please explain the nature of harm and how often: ______________________________________

Have you ever intentionally hurt someone else? Yes or No

If yes, please explain: ____

Have you ever experienced any form of traumatic experience? Yes or No

If yes, please explain: ____

Have you personally experienced abuse or assault of any kind? (please circle)

None Unsure Verbal Physical Emotional Sexual

Is there anything else you would like your therapist to know?

____

____

____

Thank you for your valuable time and effort!