Serenity
Psychological Services & Consulting

1010 Downing Ave Ste 60
Hays, KS 67601
Phone: (785) 621-4417
Fax: 1(866) 473-6903

Biographical Information – Intake Form - Youth

Please fill out this biographical background form as completely as possible. It will help us in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: _____ DATE: _____

NAME OF YOUTH'S PARENT(S) OR GUARDIAN(S)_____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: H: _____ Cell: _____ Work/Off: _____ Fax: _____

FOR ROUTINE MESSAGES: Phone #_____ Email: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ Email: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

ANY ISSUES RELATED TO SCHOOL PERFORMANCE OR BEHAVIOR:

_____

_____

PERSON & PHONE NO. TO CONTACT IN EMERGENCY: _____

REFERRAL SOURCE: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

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PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, brief statement about the relationship.):

Father:_____

_____

_____

Mother: _____

_____

_____

Stepparents:_____

_____

_____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. _____
2. _____
3. _____

MEDICAL DOCTOR (S) (name/phone): _____

_____

_____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_____

_____

SPECIFY MEDICATION youth presently taking and for what. PRINT clearly:

_____

_____

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PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

_____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

_____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):
1. _____

_____

2. _____

_____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

DESCRIBE CHILD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

IF PARENTS DIVORCED: Youth age at the time: _____.
Describe how it affected youth at the time

_____

_____

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ESTIMATE HOW MANY HOURS/DAY YOUTH SPENDS ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):
Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____
Work/School: _____ Other: _____

DO YOU FEEL YOUR CHILD'S TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

IS YOUTH INVOLVED IN ANY LEGAL PROCEEDINGS OR DOES YOUTH HAVE A HISTORY OF ARREST OR LEGAL PROBLEMS?

_____

_____

What gives the youth the most joy or pleasure in his/her life?

_____

What are the youth's main worries and fears?

_____

What are the most important hopes or dreams you have for the youth?

_____

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HIPAA NOTICE OF PRIVACY PRACTICES

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

II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law we are required to insure that your PHI is kept private. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office and on our website**.** You may also request a copy of this Notice from us, or you can view a copy of it in our office or on our website, which is located at **(www.serenitypsc.com).**

III. HOW WE WILL USE AND DISCLOSE YOUR PHI.

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:

1. For treatment. We can use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with our trainees and interns. We may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, we may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. We may disclose your PHI to facilitate the efficient and correct operation of our practice. Examples: Quality control – we might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. We may also provide your PHI to our attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.

3. To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for our office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

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B. Certain Other Uses and Disclosures Do Not Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: We may make a disclosure to the appropriate officials when a law requires us to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to Kansas Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **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 the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the Kansas Child Abuse and Neglect Reporting law.** For example, if we have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the Kansas Elder/Dependent Adult Abuse Reporting law.** For example, if we have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.
11. **For health oversight activities.** Example: We may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: We may disclose PHI of military personnel and veterans under certain circumstances. Also, we may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** We may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: We may use PHI to provide appointment reminders. We may use PHI to give you information about alternative treatment options, or other health care services or benefits we offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we haven't taken any action subsequent to the original authorization) of your PHI by us.

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IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of our receiving your written request. Under certain circumstances, we may feel we must deny your request, but if we do, we will give you, in writing, the reasons for the denial. We will also explain your right to have our denial reviewed.

If you ask for copies of your PHI, we will charge you not more than $.25 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

C. The Right to Choose How we Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures we Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you**.**

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VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us at: **Robert Yates III, Ph.D., Serenity Psychological Services and Consulting LLC, 1010 Downing Ave Ste 60, Hays, KS 67601 or (785) 621-4417.**

VII. NOTIFICATIONS OF BREACHES

In the case of a breach, **Serenity Psychological Services and Consulting LLC** is required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, **Serenity Psychological Services and Consulting LLC** is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. **Serenity Psychological Services and Consulting LLC** bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. **Serenity Psychological Services and Consulting LLC** may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. Individuals' Right to Restrict Disclosures; Right of Access

To implement the 2013 HITECH Act, the Privacy Rule is amended. **Serenity Psychological Services and Consulting LLC** is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring **Serenity Psychological Services and Consulting LLC,** to provide you, the patient, a copy of PHI if you, the patient, requests it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that **Serenity Psychological Services and Consulting LLC** must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct **Serenity Psychological Services and Consulting LLC** to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that **Serenity Psychological Services and Consulting LLC** may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. NPP

Serenity Psychological Services and Consulting LLC NPP must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on Jan. 30, 2013

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OFFICE POLICIES AND GENERAL INFORMATION

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to **Serenity Psychological Services and Consulting LLC** that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by **Serenity Psychological Services and Consulting LLC**. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. **Serenity Psychological Services and Consulting LLC** will use his/her clinical judgment when revealing such information. **Serenity Psychological Services and Consulting LLC** will not release records to any outside party unless s/he is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where **Serenity Psychological Services and Consulting LLC** becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the person whose name you have provided on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct **Serenity Psychological Services and Consulting LLC**, only the minimum necessary information will be communicated to the carrier. **Serenity Psychological Services and Consulting LLC** has no control over, or knowledge of, what insurance companies do with the information s/he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on **Serenity Psychological Services and Consulting LLC** to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

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CONSULTATION: Serenity Psychological Services and Consulting LLC consults regularly with other professionals regarding his/her clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. Data on **Serenity Psychological Services and Consulting LLC's** computers is encrypted as well as e-mails and e-faxes. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Unencrypted email or text provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office. **Serenity Psychological Services and Consulting LLC's** computers are equipped with a firewall, virus protection and a password, and we back up all confidential information from our computer on a regular basis onto an encrypted hard-drive. Also, be aware that phone messages are transcribed and sent to **Serenity Psychological Services and Consulting LLC** via encrypted e-mails. Please notify **Serenity Psychological Services and Consulting LLC** if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and we will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of **Serenity Psychological Services and Consulting LLC**'**s** profession require that we keep treatment records for at least 7 years. Unless otherwise agreed to be necessary, **Serenity Psychological Services and Consulting LLC** retains clinical records only as long as is mandated by Kansas law. If you have concerns regarding the treatment records, please discuss them with **Serenity Psychological Services and Consulting LLC**. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when **Serenity Psychological Services and Consulting LLC** assesses that releasing such information might be harmful in any way. In such a case, **Serenity Psychological Services and Consulting LLC** will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, **Serenity Psychological Services and Consulting LLC** will release information to any agency/person you specify unless **Serenity Psychological Services and Consulting LLC** assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, **Serenity Psychological Services and Consulting LLC** will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact **Serenity Psychological Services and Consulting LLC** between sessions, please leave a message at the answering service (785) 621-4417 and your call will be returned as soon as possible. **Serenity Psychological Services and Consulting LLC** checks messages a few times during the daytime only, unless we are out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call the 24-hour crisis line: 1 (800) 273-8255 or the Police: 911. Please do not use email or faxes for

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emergencies. **Serenity Psychological Services and Consulting LLC** does not always check email or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee for each service before each session unless other arrangements have been made. Please notify **Serenity Psychological Services and Consulting LLC** if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, **Serenity Psychological Services and Consulting LLC** will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, *Health Insurance & Confidentiality of Records,* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, **Serenity Psychological Services and Consulting LLC** can use legal or other means (courts, collection agencies, etc.) to obtain payment.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of **Serenity Psychological Services and Consulting LLC** and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Ellis County, Kansas in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, **Serenity Psychological Services and Consulting LLC** can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. **Serenity Psychological Services and Consulting LLC** will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. **Serenity Psychological Services and Consulting LLC** may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy

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will yield positive or intended results. During the course of therapy, **Serenity Psychological Services and Consulting LLC** is likely to draw on various psychological approaches according, in part, to the problem that is being treated and an assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. **Serenity Psychological Services and Consulting LLC provides neither custody evaluation recommendation** nor medication or prescription recommendation nor legal advice, as these activities do not fall within our scope of practice.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, **Serenity Psychological Services and Consulting LLC** will discuss with you a working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, **Serenity Psychological Services and Consulting LLC's** expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first couple of meetings, **Serenity Psychological Services and Consulting LLC** will assess if we can be of benefit to you. **Serenity Psychological Services and Consulting LLC** does not work with clients who, in our opinion, we cannot help. In such a case, if appropriate, we will give you referrals that you can contact. If at any point during psychotherapy **Serenity Psychological Services and Consulting LLC** either assesses that we are not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, we will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, we would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, **Serenity Psychological Services and Consulting LLC** will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, **Serenity Psychological Services and Consulting LLC** will give you a couple of referrals that you may want to contact, and if we have your written consent, we will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, **Serenity Psychological Services and Consulting LLC** will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs objectivity, clinical judgment or can be exploitative in nature. **Serenity Psychological Services and Consulting LLC** will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either unavoidable or expected. **Serenity Psychological Services and Consulting LLC** will never acknowledge working with anyone without his/her written permission. Many clients have chosen **Serenity Psychological Services and Consulting LLC** because are personally aware of his/her professional work and achievements. Nevertheless, **Serenity Psychological Services and Consulting LLC** will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise **Serenity Psychological Services and Consulting LLC** if the dual or multiple relationship becomes

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uncomfortable for you in any way. **Serenity Psychological Services and Consulting LLC** will always listen carefully and respond to your feedback and will discontinue the dual relationship if we find it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

SOCIAL NETWORKING AND INTERNET SEARCHES: We do not accept friend requests from current or former clients on social networking sites, such as Facebook. We believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, we request that clients not communicate with us via any interactive or social networking web sites.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, we require that you contact us by 3:00pm the day prior to your scheduled appointment for re-scheduling or canceling an appointment. If an appointment is cancelled after that deadline, you will be charged a fee of $25.00 for a late cancel. If you do not call or cancel the appointment, and do not show, you will be charged $25.00 for the missed appointment. Most insurance companies do not reimburse for missed sessions. No fee will be charged for appointments that are cancelled or rescheduled before 3:00pm the day prior to your scheduled appointment.

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FEE AND PAYMENT AGREEMENT
INSURANCE AUTHORIZATION AND
ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Patient Name _____DOB _____Soc. Sec. # _____

Entry Date _____ Responsible Person_____

Relationship_____ Soc. Sec. #_____

Mailing Address _____DOB _____

City_____State_____Zip_____

H Phone _____ W Phone_____

Please list any payers including but not limited to Insurance, Medicare, and/or EAPs. List name of policy holder and DOB if other than patient. Provide a copy of your insurance card for each payer or other agreement.

Payer Name _____Policy Holder Name and DOB _____

Payer Name _____Policy Holder Name and DOB _____

Payer Name _____Policy Holder Name and DOB _____

I request that payment be made on my behalf to Serenity Psychological Services and Consulting LLC for services provided during the treatment period that commenced on the above date. I authorize Serenity Psychological Services and Consulting LLC to release to the above listed entities or their agents, and every insurance plan that I have coverage under during the course of treatment, any information needed to determine these benefits or the benefits payable for related services. I understand that the purpose of this disclosure is to determine eligibility and payment for services. I understand I may revoke this consent at any time except for information that has already been sent. Unless I revoke it earlier, this consent will expire when claims for all services provided to me have been settled. Serenity Psychological Services and Consulting LLC reserves the right to refer delinquent accounts to a professional collection agency and/or an attorney. I have read and understand the terms of the Fee and Payment Agreement and agree to pay for services provided by Serenity Psychological Services and Consulting LLC to the patient listed above according to these terms. I have received a copy and a verbal explanation of Serenity Psychological Services and Consulting LLC's insurance, billing, and payment policies (included in the notice of privacy practices and office policies and general information). I have also been provided with a copy of the fee schedule and agree to pay for all services. I understand that I am responsible for paying all fees incurred regardless of the status of my insurance and that I am responsible for notifying Serenity Psychological Services and Consulting LLC of any changes to my insurance or ability to pay. I understand that Serenity Psychological Services and Consulting LLC is charging me for services provided and that I am responsible for paying any fees prior to services rendered including copays, any outstanding balance, or the full fee for services if not covered by insurance.

_____ _____

Date Signature of Responsible Person

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Consent for Treatment and Evaluation

Identified Patient:_____ DOB: _____

Please choose one or the other:

-Adult Seeking Services (check box and sign below)

☐ I hereby consent to receive treatment and/or an evaluation.

☐ I am the legal guardian of the above named identified patient, who is 18 or older, and I hereby give my permission for him/her to receive treatment and/or an evaluation (you must provide appropriate court documentation).

-Child Seeking Services (check box and sign below)

☐ I am the parent or legal guardian of the above named identified patient, who is under age 18, and I hereby give my permission for him/her to receive treatment and/or an evaluation.

In the matter of divorce or other legal orders of custody (check one):

☐ I share joint custody of this child with: Name:_____
Address:_____
City, State, Zip:_____

(A letter will be sent to the second parent notifying them of the request for services and an invitation to participate)

☐ I have sole custody of this child.

-Minor Consenting for His/Her Own Services (check box and sign below)

☐ I am 14-17 years of age and hereby consent to receive treatment and/or and evaluation. I understand that I must authorize notification of my parents or legal guardian that I have sought services.

Initial and date on each line:

_____ _____ I have received a copy and verbal explanation of and understand the HIPAA Notice of Privacy Practices.

_____ _____ I have received a copy and verbal explanation of and understand the General Office Policies and Procedures.

_____ _____ I understand the grievance or complaint policies and procedures as presented in the Notice of Privacy Practices and General Office Policies and Procedures.

Sign Here:_____ Date:_____

Relationship to Signer:_____

Printed Name of Individual Authorized to Sign:_____

Internal Use Only: I witness that the above has stated they have an understanding of their rights and met signature requirements. I have determined that they have the capacity to make an informed decision regarding the consent to treatment and/or evaluation.

Witness Signature:_____ Date:_____

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Acknowledgement of Receipt of Notice of Privacy Practices and Office Policies

I, _____, acknowledge that I have been given the opportunity to view the Notice of Privacy Practices and the Office Policies of Serenity Psychological Services and Consulting LLC. I acknowledge that these documents are posted in the office waiting room, on the internet at www.serenitypsc.com, and I further acknowledge that I have been given the opportunity to request a copy.

I acknowledge the following as indicated by my initials:

_____ I am responsible for notifying Serenity Psychological Services and Consulting LLC if I will not be able to attend a scheduled appointment by 3:00pm the day prior to my appointment or I will be charged a fee of $25.00. If an appointment is missed without being cancelled, I will be charged a fee of $25.00. Fees for missed appointments are not covered by insurance.

_____ I understand that Serenity Psychological Services and Consulting is open from 9:00am to 5:00pm Monday through Friday and that I should contact 911 in case of an emergency or after business hours.

_____ I am responsible for payment of services at the time of my appointment.

Patient name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices and Office Policies was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____