Bethany Kiser Counseling, LLC

Client Information Sheet

Date: _____

Demographic Information:

Client Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

(Street/PO Box) (City) (State) (Zip)

Primary Phone #: _____ (Home/Cell) Secondary #: _____ (Home/cell)

Is it ok to leave a message at these #'s? _____

Would you like an email reminder for appointments? No Yes, Email address: _____

Height: _____ Weight: _____ Hair color: _____ Eye Color: _____

Religious affiliation: _____ Ethnicity: _____

I am: Single (never married) Divorced Separated (legal) Married Other_____

Employment Status: Full-time Part-time Unemployed Disabled (receiving benefits)

Employer: _____ Occupation: _____

Estimated Household Income: Under $40,000 $40,000-70,000 Over $70,000

Are you or any family member involved in farming/ranching/agricultural business: _____

Primary Insurance Coverage:

Insurance Company: _____ Insurance ID #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Policy holder's Social Security #: _____ Group #: _____

Mailing address of policy holder (if different from above): _____

Phone # of policy holder: _____

Secondary Insurance Coverage:

Insurance Company: _____ Insurance ID #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Policy holder's Social Security #: _____ Group #: _____

Mailing address of policy holder (if different from above): _____

Phone # of policy holder: _____

Emergency Contact:

Name: _____ Phone #: _____

Relationship to Client: _____

I hereby authorize Bethany Kiser, LLC to release any information necessary to expedite insurance claims. I understand that the Health Insurance Portability and Accountability Act allows for the release of Protected Health Information without the need for a signed authorization for the purposes of treatment, payment and operations. I understand and agree that although Bethany Kiser will submit claims to my insurance, this is done as a courtesy and that I am fully responsible for payment of any services rendered by this office should my insurance deny payment for any reason. I understand that if I have a co-pay that I will submit my portion of payment on the date of service.

Client Signature (if over age 19) Parent/Guardian Signature (if under 19) Date

Bethany Kiser Counseling, LLC
Informed Consent for services rendered by:
Bethany Kiser, LIMHP LMHP LPC

My Background:
I have a Masters Degree in Community Counseling from the University of Northern Colorado in Greeley, CO. I have lived in the Panhandle of Nebraska since 2008 and am licensed in Nebraska as a Licensed Independent Mental Health Practitioner, a Licensed Mental Health Practitioner and a Licensed Professional Counselor. Because I am independently licensed I have completed the required number of clinical hours treating severe and persistent mental illness that I no longer require a supervising practitioner. I have specialized training, education and experience working with children ranging in age from 2-18. I also enjoy working with adults and have extensive training and experience working with people of all ages. My Bachelors of Science Degree in psychology is from Colorado State University in Ft. Collins, CO. Prior to moving to Nebraska I practiced as a mental health and substance abuse counselor in the Denver/Metro area. I currently hold a level two Certified Addictions Counselor license in the State of Colorado. I love learning and expanding my knowledge and skill set so I actively participate in continuing education courses on a yearly basis. I belong to the American Counseling Association, National Board of Certified Counselors and the Association for Play Therapy.

Treatment Philosophy
My therapeutic approach is best described as integrative. I will do my best to provide you with what you need during the course of counseling. Each person is different, so one therapeutic approach may not work for everyone; I tailor my therapeutic style to what your specific needs are. That being said, with adults I primarily use cognitive behavioral therapeutic strategies. Our thoughts, feelings and behavior are all connected and affect each other; in order to change how we feel we must change how we think which will in turn change what we do. It is my belief that we all have a right and ability to heal, grow and eventually feel genuinely happy with ourselves. Your active participation in therapy is an absolute must. You will be asked to share openly and honestly, learn new skills and practice those skills outside of therapy. You will be asked to complete homework assignments between sessions and to have an agenda for each session you attend. I will use my knowledge and skills as a trained professional to help you reach your goals. With Children my primary methods are experiential play therapy and child-centered cognitive behavioral methods depending on the specific needs of each child. I strive to help heal parent/child relationships through attachment focused therapy.

Risks and benefits
There are so many wonderful benefits to counseling. I believe that people can change, grow, heal and live the life they want to live and be happy doing so. It is my hope that you will reach your therapeutic goals and I will be there to help you do just that. However, there are some risks to counseling which you need to be aware of. Some of the risks include: recalling painful/hurtful memories from your past, people in your life struggling to adjust to the changes you are making in therapy, and you may experience a brief period of time where things get worse before they get better. You may not experience any of these but it is important to be aware of them anyway. I will be here to support you along the way should these issues come up so please talk to me about them if they become present.

The Therapeutic Relationship
During your time in counseling you will be asked to share personal information and to be open and honest. The relationship we are starting is professional and therapeutic in nature. The Counselor-Client relationship is very different from a friendship and therefore, we cannot spend time together outside of counseling. If we see each other in the community, I will not acknowledge you unless you approach me first. Please don't take this personally, it is simply to protect your privacy.

Confidentiality and Limits to Confidentiality
My professional code of ethics and state laws require that personal information discussed with me as your therapist and any information kept in your clinical record must remain confidential. I have an electronic medical records system which stores your clinical data electronically. It is a cloud based system and is fully HIPAA compliant. Any paper forms are scanned into this system for safe keeping and the paper copy is then immediately destroyed. Even though there are other counselors and practitioners in the same physical location as me, none of the other professionals have access to your confidential information. The office staff will be able to schedule/reschedule appointments, collect co-pays, get preauthorization for your counseling services, scan documents in the electronic medical record system, etc. There are a few exceptions to confidentiality which are listed below. These are times when I am mandated by law to breech your confidentiality.

1. Medical Emergencies that require information for the handling of an emergency (names of medications, medical conditions, emergency contact person)
2. If you or another person is in imminent danger due to the threat of potential harm, danger or threat of death to yourself or another person. This situation requires notifying authorities and the potential victim.
3. If you disclose abuse or neglect of a child, elderly person or vulnerable adult I must report this to the appropriate agency (Child protective services or Adult protective services).
4. If records are court ordered by a Judge, or if there is a Court order to release medical records, I will comply with the orders of the court.

Client Responsibilities
To make this a successful experience for you it is essential that you attend scheduled sessions, actively participate in session, complete homework assigned to you, etc. If you are unable to attend your scheduled session please inform us as soon as you know you cannot make it. If you do not give us notice, this is considered a "No show no call." You will be charged $25 for a "No Show". If you have three "no shows" in the same 60 day period, you will be discharged from counseling and given referrals to other providers. Your time is valuable, and so is mine. Let's work together to make this a great experience for you! Although I will submit claims to your insurance company as a courtesy, you are ultimately responsible for your account here. Should your insurance deny payment for any reason, you assume the financial responsibility. You are agreeing to keep your account current and to pay your portion, whether that is a co-pay or balance at the beginning of each session. For account balances that are 60 or more days overdue, you will be charged a finance fee of 1% each month. I do not accept Debit/Credit cards, but do accept cash or checks. You can make your checks payable to Bethany Kiser, LLC. If you have a returned check you will be charged $40 and lose the privilege of being able to pay by check after that. Full rate fees for therapy services are as follows: $95 per hour for individual therapy, $140 per hour for family therapy, $200 for the initial evaluation/assessment and $200 per hour for forensic services (Court appearances, testifying, depositions, etc.).

Consent for Treatment

I, _____, give my permission for _____
_____ Self _____ Parent _____ Guardian (Myself or Child's name)

to be seen for the assessment of mental health concerns and ongoing treatment/counseling services by Bethany Kiser, LIMHP LMHP LPC. If the treatment is for a person under the legal age of 19, I attest that I am the legal guardian of this child and possess the legal rights to give consent for medical treatment. I have read the above carefully, understand what I have read and voluntarily sign this agreement.

_____
Signature of Client or Signature of Parent/Guardian Date

_____
Bethany Kiser, LIMHP LMHP LPC Date

Client's Rights and Responsibilities Statement

Clients have the RIGHT to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age disability or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Clients' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider
- Have provider decisions about their care made on the basis of treatment needs.

Clients have the RESPONSIBILITY to:

- Treat those giving them care with dignity and respect.
- Give providers and insurance companies information that they need. This is so providers can deliver quality care and insurance companies can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Client should call their provider as soon as they know they need to cancel visits.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below states that I have been informed of my rights and responsibilities and that I understand this information.

Signature of Client (if over age 19) Signature of Parent/Guardian (if under age 19) Date

Signature of Provider Date

Notice of Privacy Practices/Receipt and Acknowledgement of Notice

Client Name: _____ DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Bethany Kiser, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Bethany Kiser, LLC.

_____ _____

Signature of Client (if over age 19) Date

_____ _____

Signature of Parent/Guardian (if under age 19) Date

_____ _____

Signature of Witness/Staff member Date

____ Check here if Client refused to acknowledge the receipt of the Notice of Privacy Practices

Mental Health Alliance

Scheduling and Payment information

Payment for providers in this office are due at the time of service. This includes self-payments for those without insurance as well as patients who will be paying co-payment amounts and deductible amounts.

Under the Health Insurance Portability Act of 1996 (HIPAA), it is now a federal crime to defraud private insurance companies. Failure to collect co-pays is also a violation of the False Claims Act. Violations can result in fines and criminal prosecution for providers.

According to the law, we cannot routinely waive co-insurance or co-payment fees. If you feel that you are unable to pay the full amount, you must speak with the billing manager to see if there are arrangements that can be made for payment following a payment schedule. You must do this BEFORE your first appointment.

As providers, we are responsible for collecting all payments due from the patient, after which we file with your insurance company to receive the amount to be paid by insurance. If we do not collect co-insurance payments at the time of service, and a patient subsequently refuses to pay, we can be held accountable for that, and could potentially face criminal charges, and be deactivated from that insurance company as a provider for anyone using that insurance.

We are obligated to report to your insurance company any refusal of payments or delinquent payments. For the patient, not paying your co-payments could result in losing your insurance.

If you believe you will not be able to pay in full for an appointment, you must make arrangements with the billing manager in advance of the appointment.

If you do not make arrangements in advance and cannot pay for your appointment, we will assist you with contacting the billing manager and may reschedule your appointment.

I acknowledge that I have received a copy of the payment information for Mental Health Alliance and affiliate providers.

_____ _____

Signature Date

Bethany Kiser Counseling, LLC

Health History Questionnaire

(If you are the parent/guardian completing this please answer the questions as they relate to the minor child)

Client Name: _____ Date: _____

Medical Care

Primary Care Provider: _____

Will you sign a release of information for your primary care provider and me to communicate about your healthcare? Yes No

What Medical Conditions are you struggling with currently? _____

Would you describe yourself as: Underweight Thin Athletic Normal/Average Overweight Obese

How often do you exercise? Never A few times per month 1-3 days/week 4 or more days/week

How intense is this exercise? Low (walking at a leisurely pace) Moderate (brisk walk) High (running or equivalent)

What are other medical issues you think are important for me to know? _____

If the Client is under 19 years old please answer the following questions about their developmental history:

- Was the child born premature? If so, how early? _____
- Was the child exposed to drugs or alcohol during pregnancy? If so, what substance? _____
- How would you describe the child's temperament as a baby/toddler? _____
- Was the child delayed in any developmental milestones (crawling, walking, talking, potty training, etc.)? _____
- Has the child been diagnosed with a learning disability? If so, what specific disability? _____
- Has the child had any brain trauma? If yes, what and when? _____
- Were the child and parent separated for an extended period of time due to medical issues? _____

Behavioral Health Care

Previous Diagnosis: (depression, anxiety, bipolar, ADHD, etc.) _____

How long has this been struggle? Less than 6 months 6-12 months Over 2 years

Have you had counseling before? No Yes

If yes, how long ago was this? _____

What was the name of your previous counselor and agency they worked? _____

Will you sign a release of information for me to get records from your previous counselor? Yes No

Current Medications and dosage to manage mental health concerns: _____

Who prescribes these medications for you? _____

Will you sign a release of information to allow this provider and myself to communicate about your care? Yes No

Have you ever been hospitalized in a psychiatric or behavioral health unit for mental health related concerns? Yes No

If yes, what facility and when: _____

Will you sign a release of information for me to request records from your hospital stay? Yes No

What are a few of your coping skills? _____

What are 2-3 strengths about your personality? _____

What are 2-3 things you are good at/enjoy doing? _____

Other Health Care

How much caffeine do you drink daily? _____

Do you use nicotine/tobacco? If yes, how much daily: _____ Want to quit? No Yes

Do you use drugs? If yes, what substance, how much and how often: _____

Do you use alcohol? If yes, how much and how often: _____

Do you think you have a problem with alcohol or drugs? No Yes Maybe

Have you ever been treated for alcohol or drug related problems? No Yes, explain _____

Name: _____ Date Completed _____

Brief Bio-Psycho-Social History Form- Adult

Family/Social History

Where were you born?_____ Other places you've lived? _____

Who raised you? _____ Were your parents ever married? _____

Are your parents still married? _____ If no, how old were you when they got divorced?_____

Were you ever in foster-care or placed out of home during your childhood? _____

How would you describe your relationship when you were a child with: (healthy, absent, abusive, strained, etc.)

Your mom _____ Your dad _____

Step-parent(s) _____ Other caregiver(s) _____

Were you ever a victim of childhood abuse/neglect? _____

If so, was it: Verbal abuse Emotional abuse Physical abuse Sexual Abuse

Witness to Domestic Violence Neglect

How many siblings do you have? _____

Names and ages: _____

Relationship History

Are you currently: married separated divorced in committed relationship single

If you are in a relationship what is your current level of happiness? Low Moderate High

Are you seeking counseling for a relationship/marital issue? _____

Do you have children? _____ If so, names and ages: _____

Do you have concerns regarding your children, if so what are your concerns: _____

How is your relationship with your parents/caregivers (whoever raised you) now that you are an adult?

Mom/Maternal figure: _____ Dad/Father figure: _____

Adult Trauma History:

Have you experienced any traumatic event in your adult life? _____

If yes, do you believe this is currently affecting you? _____

Legal/Criminal History

Have you ever been convicted of a crime? _____

If yes, please list charges, year of conviction and any jail/prison time below: