Policy Statement and Client Information Sheet

Karen E. Goggans, M.A., LCMFT, LCPC

Lifeline Counseling Center

405 S Clairborne, Suite 1

Olathe, KS 66062

(913) 764-5463 x120

Eligibility for Service

Counseling services are provided without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

Client Rights

- To be informed about the qualifications of your therapist: education, experience and professional licensure;
- To have your therapist offer to perform and perform only those services that are consistent with her training, education, experience and accepted professional standards;
- To receive an explanation of services offered, your time commitments, fees and billing policies prior to receiving services;
- To have all that you say treated confidentially and be informed of any state laws placing limitations on confidentiality in the counseling relationship;
- To ask any questions at any time about any aspect of your counseling, and be informed of your progress;
- To participate in setting goals and evaluating progress toward meeting them;
- To be informed of how to contact your therapist in an emergency situation and any limitations to your therapist's availability;
- To request referral for a second opinion at any time;
- To request copies of records and reports to be used by other professionals when authorized by you;
- To receive a copy of the Code of Ethics to which your therapist adheres;
- To contact the appropriate professional organizations if you have doubts or complaints relative to your therapist's conduct (Kansas Behavioral Sciences Regulatory Board; American Association for Marriage and Family Therapy; American Counseling Association)
- To terminate the counseling relationship at any time.

Client Responsibilities

- To set and keep appointments; call with at least 24-hour notice if you must reschedule your appointment;
- To help plan your goals, and follow through with agreed tasks;
- To keep your therapist informed with complete and accurate information whenever it is relevant to the counseling process and your progress;
- To terminate your counseling relationship before entering into arrangements with another therapist.

Confidentiality

The information clients provide in therapy is confidential. The therapist will not reveal any information about clients or their issues without the client's written consent. Kansas Law (KSA 65-6410), however, does make exceptions to confidentiality when:

1) disclosure is required by other state laws;
2) failure to disclose the information presents a clear and present danger to the health or safety of an individual (e.g., child or adult abuse, child neglect, or potential self-harm, etc.);
3) the [therapist], employee or associate is a party defendant to a civil, criminal or disciplinary action arising from the therapy…;
4) the client is a defendant in a criminal proceeding and the use of privilege would violate the defendant's right[s]…; or,
5) a client agrees to a waiver…

Additionally, Kansas Law allows therapists to seek collaboration or consultation with professional colleagues or administrative superiors on behalf of a client.

Medical Consultation for Mental Disorders

Many clients come to counseling with no diagnosable mental disorder. However, when your therapist observes symptoms of a mental disorder, those symptoms may be the result of a medical condition or medication you are taking. Therefore, Kansas Law [KSA 65-6404 (b)(3)] requires your therapist to consult with your primary care physician or psychiatrist whenever symptoms of a mental disorder are observed. This enables your therapist and medical doctor to work collaboratively in understanding any possible physical factors related to your symptoms. However, Kansas Law does permit a client to request in writing that such medical consultation be waived. You may discuss your options with your therapist if a medical consultation ever becomes required in your case.

Philosophy and Approach to Counseling
Karen believes that during the trials of life everyone has strengths to help pull them through those difficult times. Working with adults, couples, and families, Karen incorporates the significance of relationships into her counseling techniques; addressing social, personal, and medical considerations. Please feel free to ask Karen for more information on the practical implications of this approach to your particular situation. Karen does both short-term problem solving and longer-term growth work.

Education and Training
Bachelor of Science in Family Relations, Lipscomb University; *Master of Arts in Counseling*, MidAmerica Nazarene University

Continuing Education
Karen is a licensed clinical marriage and family therapist in the state of Kansas (LCMFT) and a licensed clinical professional counselor (LCPC) in the state of Kansas. In order to stay at the top of her field and help ensure the best care for her clients, Karen regularly pursues continuing education opportunities each year.

Professional Affiliation and Ethical Codes
As a member of the American Association of Marriage and Family Therapy (AAMFT) and the American Counseling Association (ACA), Karen adheres to their Code of Ethics; you may request a copy of these codes at any time. Karen also practices according to the standards of the Kansas Behavioral Sciences Regulatory Board.

Benefits and Risks
Any time individuals seek therapy to work on difficulties within themselves or in their personal relationships; there are potential benefits and risks. Benefits may include the ability to handle specific concerns and/or interpersonal relationships in a healthier way. Clients may also gain a greater understanding of personal, interpersonal, or family issues. This new understanding may lead to greater maturity and happiness as an individual, couple, or family. There may also be other benefits that come as clients work at resolving specific concerns.

However, therapy is also sometimes challenging and uncomfortable. Reviewing and resolving unpleasant issues may result in intense feelings of anxiety, anger, depression, or frustration. As clients work to resolve personal issues or issues between family members, spouse, and other persons, they may experience discomfort and an increase in conflict. Changes in relationships that were not originally intended may also result.

The therapist will discuss with clients the benefits and risks involved in their particular situation. Clients are encouraged to discuss with the therapist any concerns they may experience at any time.

Length and Frequency of Therapy and Termination
The nature and severity of clients' presenting problems, along with available time and financial considerations, are generally the main factors that determine the length and frequency of therapy. Counseling can range from a few sessions to many months of therapy, with the most common meeting frequency being weekly or every other week. The estimated length and frequency of a client's counseling is determined in a collaborative discussion between client and therapist. Regular reviews of the client's progress and continuing need for therapy are discussed with the client. Clients may leave therapy at any time, but the therapist asks that they agree to discuss the termination of therapy at a regular therapy session, rather than by phone.

Appointments and Fees
1) All services are provided by appointment, scheduled directly with your therapist.
2) If you need to change or cancel an appointment, call your therapist with at least 24-hours notice.
3) The fee for therapy is $120 for an intake session (45-50 minutes) and $90.00 for a standard 45-50 minute session. Fee amounts are variable dependent upon client's ability to pay and insurance coverage.
4) Clients are expected to pay for each session at the time of their appointment.
5) Billing of insurance (in-network and out-of-network) will be handled by the administrative office of Lifeline Counseling Center. All clients are responsible for their co-pay amount at the time of service.
6) Clients may be asked to undergo assessment using standardized and computer-scored tools, or to use printed or other resources in the course of therapy. These assessment tools and resources can range in cost from the price of a book to much more. Clients are fully informed of the reasoning for any additional assessments or resources and the costs, and such resources are utilized only with client agreement.
7) If I am requested or required to appear in court, there will be a $250 court appearance fee as well as a $120/hourly fee assessed for my time. Additional fees may apply for phone calls, e-mails, copying of files, report writing, or any other administrative work required for court involvement.

Emergency Policy

In the event of a life threatening emergency you should first call 911, or get to the nearest hospital emergency room, or utilize some other appropriate crisis or emergency service. Karen is very interested in any emergency you may face, but she cannot guarantee her 24-hour availability; clients should not assume she is able to provide emergency or crisis care. In *non-life threatening emergencies* you may call Karen at **(913) 764-5463 x120.** A phone voicemail system is available to take messages if Karen is not immediately able to accept your call. Messages are returned as soon as possible. Clients may also contact one of the following crisis hotlines; however, while these numbers are provided in good faith, no guarantee is made as to the adequacy of any one of these resources to assist you with your particular emergency at a given time:

Domestic Violence	(816) 995-1000	Johnson Co. Mental Health	(913) 782-2100
Child Abuse	(800) 922-5330	Rape Crisis Line	(913) 642-0233
Suicide	(913) 831-1773	Battered Women's Shelter	(913) 262-2868

IF YOU HAVE ANY QUESTIONS AT ALL REGARDING THE PRECEEDING POLICIES AND INFORMATION, PLEASE TALK TO YOUR THERAPIST FOR CLARIFICATION. THIS "POLICY STATEMENT AND CLIENT INFORMATION SHEET" IS A PART OF THE "INFORMED CONSENT & THERAPY CONTRACT" THAT YOU WILL SIGN SHOULD YOU DECIDE TO PROCEED WITH COUNSELING.

Notice of Privacy Practices Pursuant to HIPAA
Effective date: August 15, 2005

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact Karen E. Goggans, M.A., LCMFT, LCPC at 913-764-5463 x120.

Privacy is a very important concern for all those who come to this office. Federal and state laws and the codes of our profession make the issue of privacy very complicated. Some parts of this notice are quite detailed, and you may have to read the notice several times. If you have any questions, your therapist (Privacy Officer) will be happy to help you.

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A. Introduction

This notice will tell you how this office handles information about you. It tells how information is used, shared with other professionals and organizations, and how you can see your information. This notice is required under the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. What is meant by "your health information"

Each time you visit this office or any other "health care provider", information is collected about you and your physical and/or mental health. It may be information about your past, present, or future health or conditions, or about the treatment or other services you have received or about payment for health services. The information collected from you is called Protected Health Information (PHI). This information goes into your file. In this office, your PHI is likely to include these kinds of information:

- Your history as child, in school, and at work, and marital and personal history
- Reasons you came for treatment/counseling. This includes your problems, complaints, symptoms, needs, and goals
- Diagnoses
- Treatment plan
- Progress notes. Each time you come in, your therapist will write down how you are doing, observations, and what you tell him or her
- Records received from others who have treated you or evaluated you
- Information about medications you took or are taking
- Legal matters
- Billing and insurance information

PHI is used for many purposes. For example, it may be used:

- To plan your care and treatment
- To decide how well treatment is working for you
- When speaking with other health care professionals who are also treating you, such as your family doctor or someone who referred you
- To show what services you have actually received
- For teaching and training other health care professionals
- For psychological research
- For public health officials trying to improve health care in this county

- To improve the way I am doing my job by measuring the results of my work

When you understand what is in your record and what it is used for, you can make better decisions about how, when, and why others should have this information.

Although your health record is the physical property of the practitioner or facility that collected it, the information in your health record is available for you to see, and you are entitled to copies of the file. *Psychotherapy notes are working notes and belong to the therapist and are not part of your health record.* You can inspect, read, or review the health record. If you want a copy, we can make one for you but may charge you for the costs of copying and mailing if you want it mailed. In some very unusual situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or something important is missing you can ask us to amend (add information to) your record, although in some rare situations the therapist does not have to agree to do that. Your therapist can explain more about this to you.

C. Privacy and the laws about privacy

The HIPPA law requires therapists to keep your PHI private and to give you this notice of legal duties *and* privacy practices, which is called the *Notice of Privacy Practices*, or NPP. Your therapist will obey the rules of this notice as long as it is in effect, but if the NPP is changed, the rules of the new NPP will apply. If the NPP is changed, the new Notice will be posted in the office where everyone can see it. You or anyone else may obtain a copy of the NPP at any time.

D. How your PHI can be used and shared

When your therapist or others under the direction of the therapist read, share, utilize and analyze your information in the office that is called "use." If the information is shared with or transmitted to others outside the office, that is called, "disclosure." Except in some special circumstances, when your PHI is used or disclosed, only the minimum necessary PHI is shared. The law gives you rights to know about your PHI, how it is used and to have a say in how it is disclosed.

Your PHI is used and disclosed for several reasons. Mainly, your PHI will be used and disclosed for routine purposes explained more fully below. For other uses, you must be told about them, and your therapist must have a written Authorization from you, unless the law allows or requires use or disclosure of PHI without your authorization. You may revoke your authorization for release of information at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that your therapist has relied on the authorization, or if the authorization was obtained on the condition of obtaining insurance coverage where the law provides the insurer the right to contest the claim under the policy. The law also says that therapists are allowed to make some uses and disclosures without your consent or authorization, and those situations are discussed below.

1. Uses and disclosures of PHI without your consent

a. For treatment, payment, or healthcare operations

In almost all cases, your PHI will be used to provide treatment to you, arrange for payment for services, or some other business functions called health care operations. These routine purposes are called TPO (Treatment, Payment, Healthcare Operations). An authorization form signed by you is not required in order for your PHI to be used for TPO. However, in order to provide therapy services, you will be asked to sign an informed consent for treatment form.

Treatment. Your healthcare information will be used to provide you with psychological treatment or services. These might include individual, couple, family, or group therapy, psychological testing, treatment planning, or measuring the effects of services. Your PHI may be used or disclosed to others who provide treatment to you. Your information may be shared with your personal physician. If a team of providers is treating you, we can share some of your PHI with them so that the services you receive will be coordinated. Others may enter their findings, the actions taken, and treatment plans into your record. Then, a decision can be made on what treatments work best for you. A treatment plan will be developed. You may be referred to other professionals or consultants for services this office cannot offer, such as special testing or treatments. When referral occurs, the referring clinician will need to be told about you and your conditions. Information received will go into your record. If you receive treatment in the future from other professionals, your PHI from the records at this office may be requested with your authorization and shared. These are only some examples of how your PHI may be used and disclosed.

Payment. Your PHI may be used to bill you, your insurance carrier or others as you request or authorized. Your insurance company may be called in order to determine your insurance coverage. Your insurance carrier may have to be told about your diagnoses, what treatments you have received and is expected throughout treatment. The insurance carrier will need to be told when treatment began, your progress, and other similar information.

Healthcare operations. There are some other ways your PHI may be used or disclosed. Your PHI may be used to determine where improvements need to be made in the way the health care provider provides services. It is possible that the office could be required to supply information to some government health agencies studying disorders and treatment services. If so, your name and identity will be removed from what is provided.

b. Other uses in healthcare

Appointment reminders. Your PHI may be used and disclosed in order to reschedule or remind you of appointments. If you want to be called or written to only at your home or your work, or if you prefer some other way to be contacted, that can usually be arranged. You may be asked to complete a form.

Treatment alternatives. Your PHI may be used to tell you about or recommend possible treatments or alternatives that may be of interest to you.

Other benefits and services. Your PHI may be used and disclosed in order to tell you about health-related benefits or services that may be of interest to you.

Research. Your PHI may be used or disclosed in order to research treatments. In all cases your name, address, and other identifying information that reveals who you are will be removed from the information given to researchers. If there is a need for your identity to be disclosed, the research project will be discussed with you and, if you wish, you may agree to sign a special Authorization form before identifying information is shared.
Business associates. There are some tasks that may be outsourced to other businesses. Examples would include a copy service used to make copies of your health care record, and billing services who completes and mails billing statements. These business associates may receive some of your PHI to do their jobs properly. To protect your privacy, the business associates have contracted to safeguard your information.

2. Uses and disclosures requiring your authorization

If your therapist wishes to use your information for any purpose besides the TPO described above, your permission is needed on an Authorization Form. You may revoke your authorization for release of information at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that your therapist has relied on the authorization, or if the authorization was obtained on the condition of obtaining insurance coverage where the law provides the insurer the right to contest the claim under the policy.

3. Uses and disclosures of PHI <u>not</u> requiring authorization or consent

Child Abuse – If your therapist has reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, your therapist MUST report the matter to the appropriate authorities as required by law.
Adult and Domestic Abuse – If your therapist has reasonable cause to believe that a dependent adult is being or has been abused, neglected or exploited or is in need of protective services, your therapist must report this belief to the appropriate authorities as required by law.
Health Oversight Activities – Your therapist may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services provided you and/or the record thereof, such information is privileged under state law, and your therapist will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
Serious Threat to Health or Safety - If your therapist believes that there is a substantial likelihood that you have threatened an identifiable third person or the public at large and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
For law enforcement purposes. Your PHI may be released under certain circumstances to law enforcement officials investigating a crime.
For specific government functions. Your PHI may be disclosed to military personnel and veterans, to government benefit programs relating to eligibility and enrollment, to Workers' Compensation programs, to correctional facilities if you are an inmate, and for national security reasons.

4. Uses and disclosures requiring you to have an opportunity to object

Information can be shared with your family or close others, but only those involved with your care and those you choose, such as close friends or clergy. You will be asked what information can be shared about your condition and treatment. Your therapist will honor your wishes as long as it is not against the law. If there is an emergency – and in that case you may not be asked if you agree – personal information may be shared if your therapist believes that it is in your best interests.

5. An accounting of disclosures

You are entitled to an accounting (a list) of disclosures of your PHI. The accounting includes what was disclosed, when it was disseminated, and the person/agency that received the information.

E. If you have questions or problems

If you need more information or have questions about the privacy practices described above, please speak to your therapist (Privacy Officer), whose name and telephone number are listed on the top page of this Notice. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact your therapist. You have the right to file a complaint with your therapist, with the Kansas Behavioral Sciences Regulatory Board at 785-296-3240, and with the Secretary of the Federal Department of Health and Human Services. Filing a complaint will not result in a limitation of care.

The effective date of this notice is August 15, 2005.

CLIENT INTAKE INFORMATION

This information is used by your therapist for administrative purposes, and to become familiar with your presenting concerns, history, and possible areas of mental health and wellness to be worked on in your counseling services. Please answer as thoroughly as you can. Thank you for giving us the opportunity to serve you.

Date ______________________

Client Information

First Name _________________________Middle Initial _________Last Name ___________________________

Nickname _________________________ Gender: □ Male □ Female

Date of Birth ______/____/________ Social Security Number____________________________
(required by most insurance companies)

Marital Status: □ Married □ Single □ Separated □ Divorced □ Other (explain)_________________

Employment: □ Employed □ Full-time Student □ Part-time Student □ Unemployed/Other

□ **HIPAA Agreement was provided (sign here):** ____

Telephone: ☐ Mobile ( ) _______________________ □ No messages □ Voice Messages □Text Messages

☐ Home ( ) _______________________ □ No messages □ Voice Messages

☐ Work ( ) _______________________ □ No messages □ Voice Messages □Text Messages

Preferred Phone:_____________________________

Email Address:____

Address ____
Street City State Zip

Employer ____

Employer Address____
Street City State Zip Phone

Occupation/Title/Position:____

Background Information

Spouse &/or Parents Name (circle which applies)________ ____
Date of Birth ________/______/________ Social Security Number______________________________

Address ______________________________________Employer ____

Telephone: Mobile ( ) __________________ Work ( ) _____________ May I contact them at work? _____

Please list additional family members living with you:

Name Relationship Date of Birth Employer/School

F. ____

G. ____

H. ____

I. ____

Who may we contact in the event of an emergency?

Name:______________________________________ Phone number:___________________________
Relationship?____

Please describe briefly the concern or situation, which led you to seek services at this time:

____

____

____

How long has this been a concern?_________________________

Have you experienced this type of concern before? □ YES □ NO If so, when?_____________________

Have you had any significant events, either positive or negative, occur recently or in a notable amount of time, such as job/school changes, death(s), changes in finances, living situation, illness, infertility, etc?
____

____

Physician ____

Name Address Phone #

Do you regularly have physical wellness check-ups? □ YES □ NO

If you have noticed any recent changes in the following areas, please circle those changes:

A) vision, hearing, coordination, balance, strength, speech, memory, or thinking
B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

Are you currently seeing a counselor, therapist, psychologist, or psychiatrist ◻ YES ◻ NO
If yes, who?____

Have you ever had counseling before? ◻ YES ◻ NO
If so, when and why? ____
____

Was it helpful? ◻ YES ◻ NO If not, why not?_______________________________________

Have you ever had medication prescribed for psychiatric or emotional difficulties? ◻ YES ◻ NO
If so, please list [**Include current medications**]:
____
____

Have you ever been physically, sexually, or emotionally abused? ◻YES ◻ NO
If yes, briefly describe:
____
____

Have you ever been hospitalized for mental or nervous problems? ◻YES ◻ NO
If yes, when and where: ____

Are you experiencing any issues related to sexuality (i.e. sexual identity, compulsive pornography use, desire, performance, etc.)? ◻ YES ◻ NO
If yes, please explain:____
____
____

Have you ever attempted suicide? ◻ YES ◻ NO
If yes, how and when:____
____
Are you suicidal now? ◻ YES ◻ NO

How often do you drink alcohol? ____
Have you ever been arrested for driving under the influence (DUI)? ◻ YES ◻ NO

Do you smoke or use tobacco? ◻ YES ◻ NO
If yes, how much?____

Do you use recreational drugs? ◻ YES ◻ NO
If yes, what drugs do you use and how often?_____________________________________

Do you have any concerns about alcohol/drug usage by members of your family? ◻ YES ◻ NO
If yes, please explain:____

____

Are you currently involved or expected to be involved in any court related matters? ◻ YES ◻ NO
If yes, please describe:____

____

Have any of your biological relatives had concerns similar to yours, or had any other psychiatric or emotional difficulties? ◻ YES ◻ NO
If yes, which relatives and what kind of concerns/difficulties:____

____

Religious and Spiritual
Do you consider yourself spiritual? ◻ YES ◻ NO Religious? ◻ YES ◻ NO
Comment?____

Do you currently express this spirituality through religious practice? ◻ YES ◻ NO
Comment?____

Would you like spirituality included in your counseling? ◻ YES ◻ NO

Church affiliation____

How did you hear about Lifeline Counseling Center or your counselor (check all that apply)?
____Google _____Yahoo _____ Bing ____Facebook ____Psychology Today
_____Agency/Organization (which?________________________________)
____Lifeline Counseling Website
____Pastor, Priest, Rabbi, Church, etc. (which?____)
____Insurance referral______________________________ ____ Dr.____________________________
____Individual (who?______________________________) ____Other (please specify______________)

If applicable, do I have permission to thank the person who referred you? ◻ YES ◻ NO

Contact Name and Number____

Demographic Information (optional…may skip this section and go to next page)

This information is confidential and used for statistical purposes. Providing demographic information is voluntary.

Ethnicity: ____Caucasian/White ____American Indian/Alaska Native ____Middle Eastern
____African American/Black ____Native Hawaiian/Pacific Islander ____Asian
____Hispanic/Latino ____Other ______________________________

Education of Adults in Household (put initials of each adult if more than one):
____Some High School ____Associate's Degree ____Doctorate
____High School Graduate ____Bachelor's Degree ____Trade/Specialty
____Some College ____Master's Degree ____Other ___________________

Presenting concerns: (check all that apply – if attending couples or family counseling please put initials of each person next to the concerns that apply.)

___very unhappy ___impulsive ___undependable ___self-control
___insecurity ___obsessive/compulsive ___intense headaches ___ stealing
___irritable/critical ___nervousness ___ temper outbursts ___bullying
___no joy ___panic attacks ___employment problems ___loneliness
___withdrawn/isolation ___racing thoughts ___repetitive/ritualistic behaviors ___grief
___tiredness ___fearful ___seizures ___lying
___frustration ___shyness ___financial stress ___flashbacks
___moody ___worry ___legal problems ___nightmares
___depression ___health problems ___problems w/ex-spouse ___eating problems
___memory loss ___self-harming ___sexual problems ___sleeping problems
___short attention span ___stressed out ___relationship issues ___bed wetting
___concentration difficulty ___destructive ___affair ___school issues
___crying spells ___excessive daydreaming ___divorce/separation ___ work/career issues
___lack of energy ___hair pulling ___significant alcohol use ___pornography use
___lacks motivation ___mean to others ___problems with friends ___drug use
___difficulty making decisions ___distractible ___parenting problems ___social problems
___emotional abuse ___paranoia ___stomach/bowel problems
___sexual abuse ___strange thoughts ___chronic pain
___physical abuse ___strange behavior ___problems w/parents
___homicidal thoughts
___suicidal thoughts

Explain:____
____
____
____
____
____

What are your goals for treatment (what do you want to accomplish with counseling?)
1)____
____
_________________2)____
____
__________________________________3)____
____
____

Is there anything else that you feel is important for your therapist to know?
____
____
____

INFORMED CONSENT & THERAPY CONTRACT

Karen E. Goggans, M.A., LCMFT, LCPC
Lifeline Counseling Center
405 S Clairborne, Suite 1
Olathe, KS 66062
(913) 764-5463 x120

It is important that you are fully informed about the services you will receive. By signing below you are saying:

J. I have received and read the "**Policy Statement and Client Information Sheet"** for this therapy site to help me make an informed decision about entering therapy; my therapist has answered any questions I have had to my satisfaction, and I understand and agree to the policies and terms stated therein.

K. I understand that the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT) and the American Counseling Association (ACA) binds my therapist, and I can request a copy of these ethics at any time.

L. According to AAMFT ethical code 3.14, I understand that I may not subpoena the counselor or the records into a court of law in any divorce or custody litigation.

M. I understand the confidentiality policies detailed in the **"Policy Statement and Client Information Sheet",** including the circumstances in which Kansas Law may permit or mandate limits to confidentiality.

N. I understand that there are risks and benefits associated with therapy and I have discussed those with my therapist to my satisfaction. I also understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

O. I understand that I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session, rather than by phone.

P. I understand that some clients come to counseling due to symptoms of a mental disorder. If this is or becomes the case for me, under Kansas Law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, if such ever becomes necessary, my therapist will request that I complete an **"Authorization & Request for Release of Confidential Information and Privileged Communication"** form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.

Q. I understand the appointment and financial policies of this therapy site as detailed in the **"Policy Statement and Client Information Sheet**" and **"Cancellation Policy"**, and I agree to pay at the beginning of each session the amount owed. I understand that I am responsible for full payment of services provided and that insurance benefits are not a guarantee of payment.

My signature below indicates that I give my full and informed consent to receive therapy services from this site.

Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date

Karen E. Goggans, MA, LCMFT, LCPC
c/o LifeLine Counseling Center
405 S. Clairborne, Suite 1
Olathe, KS 66062
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CANCELLATION POLICY

When you make an appointment, I reserve that time specifically for you. A canceled appointment delays our work and your progress. If you do not show or cancel late, I lost revenue, but just as importantly, I lost time. Therefore, I ask that you notify me as soon as possible, but no later than 24 hours in advance, if you need to cancel or reschedule a session. I am rarely able to fill a canceled session unless I know at least 24 hours in advance. Without such notification, you will be charged a fee of $45 for the missed session, which is half the standard rate of therapy.

You may call me directly at (913) 764-5463 x120 or (913) 735-9127 to cancel or reschedule. I understand that sometimes illness for you, a child, or emergencies necessitate cancellation with less than 24 hours notice. Sometimes this happens for me as well. I do not charge for these types of situations. I ask that you give me as much notice as possible so that I can offer this appointment to another client who may be in need of services.

All treatment sessions are by appointment only. Your appointment is a specific block of time that is reserved just for you. Late arrival for an appointment will result in a shortened session and full payment for the scheduled treatment time will be charged.

I have read and understand the cancellation policy.

Client Signature ____________________________

Date ________________