KILLEEN
COUNSELING SERVICES, LLC

6744 Clayton Rd, Ste 221
St. Louis, MO 63117

Phone: (314) 720-2710
Fax: (888) 501-1330

For Office use:

Diag. Code _____ Diag: Receipt _____

Today's Date: ____/____/_____

PERSONAL INFORMATION

Full Name: _____ Date of Birth: _____ Soc. Sec. # _____

Address: _____ City _____ State____ Zip _____

Home Phone: (___)_____ Preferred to be contacted :(____)_____

Education: High School [ ] College [ ] Other_____

Occupation: _____ Employer: _____ Phone # _____

Religious/ Church Affiliation: _____ Active [ ] Moderate [ ] Inactive [ ]

Relationship(s) you can depend on for help at present time: _____

Personal character traits and/or beliefs that you can rely upon right now _____

Referred by: _____ Address:_____ Phone #_____

FAMILY INFORMATION

Marital Status: Single [ ] Married [ ] How long? _____

Spouse's Name: _____ Phone # _____

Divorced [ ] Separated [ ] Widowed [ ] Common-law [ ]

Previous Marriage(s): Name(s) _____Duration _____

Spouse's Education: High School [ ] College [ ] Other_____

Spouse's Occupation: _____ Employer _____ Phone # _____

Children (please list names and ages):_____

_____

KILLEEN
COUNSELING SERVICES, LLC

HEALTH INFORMATION

Rate your current health: Very good [ ] Good [ ] Average [ ] Declining [ ]

List current medical problems/diagnosis(s)/medications and dosages:

_____

_____

Primary Physician: _____ Phone: _____

SPOUSE HEALTH INFORMATION

Rate your current health: Very good [ ] Good [ ] Average [ ] Declining [ ]

List current medical problems/diagnosis(s)/medications and dosages:

_____

_____

Primary Physician: _____ Phone: _____

PREVIOUS COUNSELING HISTORY

Have you previously sought counseling? Yes [ ] No [ ]

Therapist _____ Profession _____ From _____ To _____

Therapist _____ Profession _____ From _____ To _____

Describe what was helpful and unhelpful in the way your previous therapist(s) worked with you?

_____

_____

Receipt of Privacy Practices Written Acknowledgement Form

I have received a copy of Killeen Counseling Services, LLC Notice of Privacy Practices (see below).

Date:_____ Signature of Client: _____

Date:_____ Signature of Client: _____

KILLEEN
COUNSELING SERVICES, LLC

CONSENT FOR TREATMENT (For Adults 18 and over only)

Client Name _____

Date of Birth _____

As a client of our office it is your right to have the content of your therapy sessions held in confidence with these exceptions in which we are mandated to report: 1) if you sign a release form for us to divulge any or all information, 2) if you intend suicide, 3) if you intend homicide, 4) in the case of child, elder or handicapped abuse.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior. Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

In following ethical and professional standards, our licensed therapists and counselors in training consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations.

I have read and agree to the above policy, procedure and statement.

_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	
Signature of Counselor	Date	

KILLEEN
COUNSELING SERVICES, LLC

Consent Agreement for Therapy with a Minor

I, _____, the parent/legal guardian #1 and

I, _____, the parent/legal guardian #2 of

the minor, _____, whose birthday is

____/___/____, give my permission for Lauren Kofron, MA, PLPC to counsel

_____ at Killeen Counseling Services.

_____ _____
Parent or Guardian #1 Signature Date

_____ _____
Parent or Guardian #2 Signature Date

_____ _____
Counselor Signature Date
(As witness)

KILLEEN
COUNSELING SERVICES, LLC

VIRTUAL SESSION CONSENT FORM

I (we) authorize Lauren Kofron, PLPC to use Zoom (a HIPAA-compliant Platform) to conduct remote sessions. The therapist will conduct Video sessions in a secured (not public) location for the confidentiality of the clients. The therapist agrees that no other persons will be viewing these remote sessions without the expressed written consent of the clients.

This consent form can be withdrawn at any time by writing void across this form and signing it in the presence of the therapist.

_____ _____ _____ _____
Client Signature Date Other/Family Member Date

_____ _____ _____ _____
Legal Guardian Signature Date Other Family Member Date

_____ _____ _____ _____
Other Date Other Date

_____ _____
Counselor Signature Date

* Each person present for the session is required to sign this form.

KILLEEN
COUNSELING SERVICES, LLC

Consent to Email Communications (Optional)

I/we recognize that email is not a secure means to transmit data. I voluntarily waive my rights provided by federal and state laws regarding confidentiality in order to send to, or receive communications (and/or invoices) from Killeen Counseling Services, LLC via email. I voluntarily give my permission and will not hold Killeen Counseling Services, LLC and my therapist therein legally responsible for the transmission of this data.

Client Signature(s):
_____ Date _____

_____ Date _____

Email Address(s): _____

_____

Counselor Signature

_____ Date _____

KILLEEN
COUNSELING SERVICES, LLC

Payment and Missed Appointments Policies

Payment for Services: Counseling sessions usually run 50 minutes. The standard hourly fee for Lauren Kofron, MA, PLPC is $110. Additional time is billed to the quarter hour. Time billed for preparation and appearance in a courtroom deposition is $350 per hour. Our practice is to ask clients to pay as we proceed. Killeen Counseling accepts payments of cash, check, electronic check, and all major credit cards. Payments made by credit card are subject to a 3.5% billing fee. Payments made by electronic check are subject to a 1% billing fee. There are no fees for payments made by cash or paper check. Please provide your means of payment at the beginning of each session. Where insurance is applicable, we will receipt you personally with a diagnostic receipt that you may file with your insurance company who will reimburse you in accordance with your policy. Please note that: a) some companies do not reimburse for our services and, b) insurance coverage policies are often changing. This means you are ultimately responsible to ascertain coverage and initiate filing diagnostic receipts. Such receipts are given upon request. They will include a diagnosis in accord with the Diagnostic and Statistical Manual V.

Missed Appointments: Your cooperation in keeping scheduled appointments is expected. To cancel an appointment, you are required to notify our office by phone or email 48 hours in advance. If you cancel or do not keep an appointment without appropriate (48 hours) advance notice, you will be charged the full hourly fee for the tie you reserved for an appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges.

If you have any questions at all, please feel free to ask your therapist.

I HAVE READ AND AGREE TO THE ABOVE POLICIES.

_____

Client's Signature Date

_____

Client's Signature Date

KILLEEN
COUNSELING SERVICES, LLC

PERMISSION TO AUDIO OR VIDEO TAPE SESSIONS

I, _____(the client), give Lauren Kofron, MA, PLPC (the counselor) of Killeen Counseling Services, LLC (the practice), permission to record my counseling sessions on audiotape or videotape (the recordings) for the purposes of in-practice training and consultation. This will allow the counselor to share the recordings with and consult with other practice counseling staff only. Any in the practice who may personally know the client, will refrain from viewing the recordings or participating in any consultation on the case. No one outside of the practice will have access to these recordings without the written permission of the client.

This authorization shall remain in effect until such time as I, the client, cancel the authorization in writing.

_____ _____
Client Signature Date

_____
Printed Name of Client

_____
Signature of Parent/Guardian (Necessary if the client is under age 18 or has an appointed guardian)

_____ _____
Counselor Date
(As witness)

KILLEEN
COUNSELING SERVICES, LLC

Payment Authorization Form

Killeen Counseling accepts payments of cash, check, electronic check, and all major credit cards. Payments made by credit card are subject to a 3.5% billing fee. Payments made by electronic check (e-check) are subject to a 1% billing fee. There are no billing fees for payments made by cash or paper check. If paying by credit card or e-check please complete the appropriate box with signature below. You may cancel this authorization at any time. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yr) ___/_____ 3-Digit Security Code: _____
Cardholder ZIP Code (from credit card billing address): _____

E-Check Information
First Name: _____ Last Name: _____
Or
Account Holder Name (if Business): _____
☐ Checking ☐ Savings Acct. #: _____ Routing #: _____
Account Holder Signature:_____ Date: _____
Account Holder Phone Number: _____

I,_____, authorize **Killeen Counseling & Associates** to charge my credit card/electronic check above for agreed upon services. I understand that my information will be saved to file for future transactions on my account and I can cancel or change payment at any time.

Client Signature: _____

Date: _____

KILLEEN
COUNSELING SERVICES, LLC

Notice of Privacy Practices (1 of 4)

As you begin counseling, you may wonder:
How can medical information about you be used?
How can you obtain access to such information?
For answers to these and other information regarding our privacy practices please read the information below. Your counselor will also review this information in brief during your first appointment.

OUR COMMITMENT TO YOUR PRIVACY
Killeen Counseling Services, LLC is dedicated to maintaining the privacy of your health information. In conducting our practice, we will create records regarding you and the treatment and services we provide to you. This may be information about your past, present or future health or conditions, or the tests and treatment you got from us or from others, or about payment for healthcare. There may also be other kinds of information that go into your healthcare record here.

PRIVACY AND THE LAWS
Because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information.
- Your privacy rights in your health information.
- Our obligations concerning the use and disclosure of your health information.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS *With your signed consent:*
Below, we have listed some of the reasons why we might use or disclose your health information with some examples. Not every use or disclosure is discussed, but all of the ways that we are allowed to use and disclose information falls into one of these categories.
For Treatment: Our practice may use your health information to treat you. This may include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services. Many of the people who work for our practice may use or disclose your health information in order to treat you or assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your health information to other health care providers for purposes related to your treatment.

Notice of Privacy Practices (2 of 4)

For Payment: Our practice may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment so that your insurer will cover, or pay for, your treatment.
For Health Care Operations: Our practice may use and disclose your information for our practice operations to evaluate the quality of care you received from us.

For Other Uses in Healthcare:

- We may use or disclose your health information to contact you and remind you that you have an appointment for treatment or medical care.
- We may use or disclose your health information to provide you with information about or recommendations of possible treatment options or alternatives that may interest you.
- We may use or disclose your health information to a group health plan, health insurance issuer, HMO or plan sponsor.
- We may release health information about you to a friend and/or family member who is involved in your care.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your health information for the purposes described in the authorization. Please note, we are required to retain records of your care.
We can use or disclose health information about you without your authorization when there is an emergency, when we are required by law to treat you, or when we are required by law to use or disclose certain information. We may use or disclose your health information without your authorization in any of the following circumstances:

- When it is required by federal, state or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect or domestic violence;
- When disclosing information for judicial and administrative proceedings;
- When disclosing information for law enforcement purposes;
- When we believe in good faith that the disclosure is necessary to avert a serious health or safety threat;
- When disclosure is necessary for specialized government functions;
- When disclosure is necessary to comply with worker's compensation laws or purposes.

Notice of Privacy Practices (3 of 4)

PLANNED USES OR DISCLOSURES TO WHICH YOU HAVE AN OPPORTUNITY TO OBJECT:
We may use or disclose your health information with anyone you choose – family, close others, clergy - unless you affirmatively object to or otherwise restrict a particular release, as long as it is not against the law. You may direct your objections or restriction in writing to your caregiver or to the Privacy Officer listed in this Notice.

AN ACCOUNTING OF DISCLOSURES:
When we disclose your health information we may keep some records of when we sent it, what we sent, and to whom we sent it. You can get an accounting (a list) of many of these disclosures for the last six years, but not before not before January 1, 2010. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:
You have the following rights regarding the health information that we maintain about you.

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. While we are not required to agree to your request, if we do agree we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. Inspection and Copies. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Killeen Counseling Services, LLC in order to inspect and/or obtain a copy of your health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of denial. Instead of providing the health information you requested, we may provide you with a summary or explanation of the information as long as you agree to that and to the cost in advance.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to Killeen Counseling Services, LLC. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the health information kept by or for the practice; (c) not part of the health information which you would be permitted to inspect and copy; or (d) not created by our practice. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your health information.

Notice of Privacy Practices (4 of 4)

RIGHTS CONTINUED

5. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Killeen Counseling Services, LLC.

6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer as listed below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Privacy Officer
Killeen Counseling Services, LLC
6744 Clayton Rd, Ste 221
St. Louis, MO 63117
Office: (314) 720-2710
Fax: (888) 501-1330