

**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): \_\_\_\_\_

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## HEALTH INFORMATION

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

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

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Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

## SPOUSE HEALTH INFORMATION

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

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

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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?

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## Receipt of Privacy Practices Written Acknowledgement Form

I have received a copy of Killeen Counseling Services, LLC Notice of Privacy Practices (see pp. 9-12).

Date: \_\_\_\_\_ Signature of Client: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Client: \_\_\_\_\_

## 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

### 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 Shelly Simpson, Practicum Student/Intern to counsel

\_\_\_\_\_ at Killeen Counseling Services.

\_\_\_\_\_  
Parent or Guardian #1 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian #2 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Counselor  
(As witness)

\_\_\_\_\_  
Date

**VIRTUAL SESSION CONSENT FORM**

I (we) authorize Shelly Simpson, Practicum Student/Intern 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.

**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 \_\_\_\_\_

## Payment and Missed Appointments Policies

Payment for Services: Counseling sessions usually run 50 minutes. The standard hourly fee for Shelly Simpson, Practicum Student/Intern is \$40. Additional time is billed to the quarter hour. Our practice is to ask clients to pay as we proceed. We accept MasterCard, Visa, Discover, and American Express, as well as personal checks. 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 IV.

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.

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Client's Signature

Date

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Client's Signature

Date

**PERMISSION TO AUDIO OR VIDEO TAPE SESSIONS**

I, \_\_\_\_\_(the client), give Shelly Simpson, Practicum Student/Intern (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)



**Paying with Credit Card? *Please fill out the following form.***

**Credit Card Authorization Form**

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

<b>Credit Card Information</b>	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card): _____	
Card Number: _____	
Expiration Date (mm/yy): _____	Security Code: _____
Cardholder ZIP Code (from credit card billing address): _____	

I, \_\_\_\_\_, authorize **Killeen Counseling** to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## 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.

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## 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.

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## **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.

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## 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