Lynnée Rogers Counseling, LLC

Client Information

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date _____ Referred by_____

Name (s) _____ •M •F Birth Date ____/____/____

Parents names _____ •M •F Birth Date ____/____/____

_____ •M •F Birth Date ____/____/____

Parent Relational Status: Married/cohabitating, separated, divorced, widowed, single, engaged

Sibling's names/ages _____

Others living in your home _____

Address _____
Street Apt. # City Zip

Parent Primary phone _____ Okay to leave message? • Yes • No

Client phone _____ Okay to leave message? • Yes • No

Email _____
Parent Occupation & Employer _____
Client School & Grade _____

Current Client Concerns

What are the major concerns for which you're seeking counseling? _____

_____

_____

_____

On a scale of 1 (mild) to 5 (severe), how would you rate your issues? 1 2 3 4 5

How long have these issues been a concern? _____

What are your goals for counseling? _____

_____

Describe your personal strengths: _____

_____

Have you ever experienced a traumatic event in which you or someone else was harmed or could have been harmed? Please describe:_____

_____

Describe your support system (family, friends, church, etc) _____

_____

Would including spirituality in your counseling be helpful? • Yes • No

If yes, what is your religious background and/or preference? _____

Have you received counseling in the past? • Yes • No

If yes, what were the issues and was it helpful? _____

_____

_____

What was/is your previous or current mental health diagnosis? _____

Medical Information

Physicians name and practice location: _____

Current medical conditions (Allergies, diagnoses, etc.): _____

_____

Hospitalizations/major illnesses in the past 5 years (physical or mental): _____

_____

List medications and vitamin/herbal remedies taken regularly. Indicate dosage and purpose: _____

_____

Emergency Contact: _____

Name Relationship Phone

Any additional information that you believe would be helpful: _____

_____

_____

_____

_____

_____

_____

Information Disclosure and Consent Form

Counseling Purpose:
A consensus definition of counseling is that counseling is a professional relationship that empowers diverse individuals, families, and groups accomplish mental health, wellness, education, and career goals. According to the U.S. Dept. of Human Services, the primary purpose of counseling is to empower you to deal adequately with life situations, reduce stress, experience personal growth, and make well-informed, rational decisions.

Possible Therapy Goals:
Therapy goals are developed individually so that they are specific to your needs. We will work together to create goals that are attainable and that help you get where you want to be. Goals for therapy tend to center around symptom reduction or elimination, gaining insight into your specific problem, and learning skills necessary to navigate multiple life areas.

My Training and Approach to Therapy:
I have a Masters of Science in Marriage and Family Counseling earned in 2005 from Northwest Nazarene University. I am a Licensed Clinical Professional Counselor (LCPC) in the State of Idaho. My areas of special training and expertise include trauma and PTSD, although I have experience and training in many other areas. I am trained and certified in and use a variety of techniques in therapy along traditional lines including Client Centered, Cognitive Behavioral, and Humanistic approaches to a more specialized intervention, Eye Movement Desensitization and Reprocessing (EMDR). Typically a holistic approach is used which draws from a number of different therapeutic approaches. The therapeutic intervention I suggest for you will be dependent on your presenting problem and personal preferences. It is important for you to communicate how you feel your treatment is progressing as we may need to adjust treatment interventions if they are not effective for you. I may suggest that you get involved in additional or adjunctive forms of support, such as additional counseling or a support group as part of your work with me. If another health care person is working with you, I may request a release of information from you so that I can communicate freely with that person about your care.

Counseling Process:
Counseling can be a time-consuming endeavor, and the success depends on many factors including the nature of the problems, your efforts and participation in the process, your therapeutic connection to the counselor, and the counselor's skills. Most clients can expect positive results; however, at times the process may involve discussing painful or uncomfortable thoughts and feelings before positive benefits can be achieved. Occasionally you may leave a session feeling worse than when you arrived, but if you remain committed, open, and honest, positive outcomes are likely over time. Sometimes, however, you may not feel progress is being made. You should discuss this with your counselor to try to determine the barriers to progress. If you continue to feel the counseling is unsuccessful, you should request a counselor change or referral. I will always be glad to give as many referrals as needed.

Counseling Risks and Benefits:
Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others both in positive and negative ways. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, goals; increased academic or work productivity; and an ability to deal with everyday stress. Taking personal responsibility for working with these issues may lead to greater growth.

Counseling Sessions:
A counseling session is normally fifty minutes in length but can be scheduled for as little as 30 minutes and as long as 1.5 hours. Therapy sessions are usually scheduled once a week depending on the need. The average individual will come for six to nine months but this varies greatly. We will arrange the frequency and length of sessions specifically to meet your individual and/or family needs. Counseling sessions will be scheduled on a week-to-week basis. If it is necessary for you to change or cancel an appointment, please do so 24 hours in advance by calling 208-546-9395. Late cancellation fees or No-show fees may be applied after the 2nd incident. Fees are **$150** per session. If you are in a crisis or have an emergency, you may contact your local police at 911 or go to the nearest emergency room. You may also call 208-546-9395 as this number serves as on-call for emergency and after hour needs. I will respond to emergency calls within 2 hours. My office hours are typically on Mondays, Wednesdays and Thursdays 10-5, Tuesdays 10-2 and Fridays 10-4. Emergency sessions can be scheduled within 6 hours of a phone call, urgent sessions will be scheduled within 48 hours and routine visits will be scheduled within 10 days.

I am away from the office several times in the year for extended vacations or to attend professional meetings. I will give notice of any planned time away and will create a plan for you if you need sessions during my absence.

Documentation:
Documentation is maintained regarding the services you receive. You have the right to access your counseling records with written request. These records are confidential and will not be released to outside parties without your written consent. Records are kept for 7 years and will be destroyed after that time. If I am billing to an insurance company or other external agencies, they may receive information regarding your counseling for reimbursement purposes. Case notes are not typically released to anyone even when specifically requested. Documentation that is just in written form will be stored at the office in a HIPPA compliant manner and in accordance with relevant laws and statutes. Client information is managed and stored through an EHR system that is HIPPA compliant.

Diagnosis:
If a third party, such as an insurance company, is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. This will be determined during our initial evaluation and may be changed or be amended throughout counseling.

Professional Standards:
I am required to adhere to the ACA Code of Ethics as adopted by the Idaho Counselor's Licensing Board. I am happy to provide a copy upon request or you can find a copy at http://www.counseling.org/Resources/aca-code-of-ethics.pdf. The Idaho Counselor's Licensing Board has the general responsibility of regulating the practice of licensed professional counselors. The licensure of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of treatment. Sexual intimacy between a counselor and client/patient is never appropriate, and should be reported to the Idaho Counselor Licensing Board immediately. The Idaho Bureau of Occupational Licenses. 700 West State Street, Boise, ID 83702 (208) 334-3233 http://ibol.idaho.gov/IBOL

Confidentiality:
With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. If we meet outside of the counseling session, I will keep confidentiality by not acknowledging that I know you, to protect your privacy. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

- If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the appropriate authority within 24 hours.
- If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality to get help for you.
- If I believe myself to be in danger or if there is information which may jeopardize my safety I may legally break confidentiality
- In the event of a medical emergency, emergency personnel may be given necessary information.
- If you are involved in a court proceeding and a request is made for information concerning the professional services that you have been provided, such information without your written authorization, or a court order may be released.
- If you file a complaint or lawsuit against me, I may disclose relevant information regarding your treatment in order to defend myself.
- If you are a minor, your legal parent/guardian has access to your records.

It is my responsibility to maintain your confidentiality in the unlikelihood of my death or incapacitation. In an event of that nature, Julie Barrass, a Licensed Clinical Professional Counselor, will be the custodian of all my records until which time they can be destroyed.

You may choose to engage in electronic communications with me. With respect to electronic mail (e-mail) or texting, it is important for you to know that it is not a confidential means of communication. I do not use an encryption program on my e-mail at this time although I do use a secure Google account. Furthermore, I cannot ensure that e-mail messages will be received or responded to if I am not available. E-mail is not the appropriate way to communicate confidential, urgent, or emergency information. Therefore, you are encouraged to contact me at 208-546-9395 if you have urgent needs.

I use an EHR (electronic health records) online software as well as Square, Inc for payments. I have a Business Associate agreement with both and they also maintain your information under HIPPA compliance.

I may engage in consultation with other licensed professionals as is recommended by the ACA Code of Ethics. If your case is discussed, any identifying information will be omitted to protect your confidentiality.

Court Disclosure:
It is my policy NOT to provide clinical evaluations or assessments to fulfill court requirements or for other legal purposes including child custody. I will not be involved in court-oriented activities, including testifying in custody matters. It is my intent to support you therapeutically and not to enter into legal proceedings. I will not give legal opinions or recommendations regarding custody or custodial issues. In the unlikely event that I am subpoenaed as a witness by a judge, fees for the requesting party are billed at $200 per hour with a

minimum four-hour charge. All time will be billed including preparation time, drive time, time spent waiting to testify, and actual time spend on testimony. Such fees are not billable to insurance and are due a minimum of one week before the scheduled court appearance. Fees are not refundable, despite any cancellation made within 24 hours.

Grievance/Complaints:
Initial complaints should be addressed with your counselor. As a client, you have the right to make complaints regarding ethical concerns to the Bureau of Occupational Licenses as outlined under professional standards.

Fees:
This information is provided to prevent any misunderstandings so that your time in counseling can be focused on your emotional needs and not financial issues. As a courtesy, I will bill your primary insurance company or provide receipts for your own billing. Please be aware that in order to accomplish this we will be supplying your insurance provider(s) with information necessary to complete the billing process. I ask that you pay your co-pay at each session or the entire fee until insurance coverage has been established. In the event you have not met your deductible for the year, the full fee is due at each session until the deductible is satisfied.

Lynnée Rogers is an LCPC, practicing for over 10 years. Her current rate is $150.00 per session and is not flexible according to insurance laws.

Please sign this sheet to indicate that you have read the information and understand your rights as a client. Also by signing this you are stating that you were given the opportunity to ask any questions regarding the above presented information and that you have agreed to receive counseling services through Lynnée Rogers.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

Parent/Guardian/Other Signature _____ Date _____

Client Rights

You have rights when it comes to participating in mental health services. The following is a list of your rights and responsibilities:

Client Rights:

- You have the right to privacy and confidentiality.
- You have the right to not be discriminated against or treated unfairly due to race, nationality, gender, sexual orientation, or religion.
- You have the right to be a participant in treatment decisions.
- You have the right to seek a second opinion.
- You have the right to file a complaint without retaliation.
- You have the right to refuse treatment and/or any services or treatment modalities and be advised of the consequences of refusal.
- You have the right to obtain clear information about your records.
- You have a right to participate in the ongoing counseling plans.

Client Responsibilities:

- You are responsible for attending appointments as scheduled or giving 24 hour notice if you cannot attend.
- You are responsible for participating in treatment and following through with homework or other tasks assigned by your counselor
- You are responsible for expressing concerns or complaints that you have to your counselor.
- You are responsible for maintaining personal boundaries and respecting boundaries that may be set by your counselor.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Notice of Privacy Practice. Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices: You have some choices in the way that we use and share information as we:

- Talk with your family about your condition (as needed)
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures: We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

Our Uses and Disclosures: we never market or sell personal information

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.** See Attached Informed Consent for further details about confidentiality and client information. Please ask questions if desiring further information.

Client Name: _____ Signature _____

Client/Parent/Guardian signature: _____ Date _____

Insurance Information Sheet

Client Name _____ Birth Date _____
MM DD YY

Insurance Company Name: _____

Policy Number _____ Group Number _____

Deductible $_____ Amount met $_____ Copay $_____ # of allowed visits_____

Relationship to Insured: • Self • Spouse • Child • Other

Please Print exactly as it appears on your Insurance Card

Insured's Name: _____ Birth Date: _____

Insured's Address: _____

Primary Phone: _____

Insured's employer: _____

Insured's SS number (Tricare/UHC only): _____

Is the client's condition related to:

Employment: • YES • NO

Auto Accident: • YES • NO

Other Accident: • YES • NO

I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers that provide financial reimbursement for requested services by Lynnée Rogers Counseling, LLC. I give consent to and acknowledge that my information may be viewed by approved billing personnel. In addition, I understand that I am responsible for payment should insurance fail or deny payment for services rendered.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____