CENTER FOR HEALING, LLC
Abigail E. Foard, MA, LPC, NCC/ The Hope Room LLC
20 W 9th St., Ste 601
Kansas City, MO 64105
Phone: 816.533.4616 email: abigail@thehoperoomkc.com

Psychotherapist-Patient Services Agreement

Welcome to therapy! It is wonderful to have you here as you prepare to embark on a journey of healing and growth.

This information is designed to help you understand the therapeutic process and the specifics of my counseling practice. It can feel overwhelming to begin the process of therapy, and this document is to help outline the specifics of what we do in the counseling office. It is important that you have a clear idea of how we will work together, and so after we go over this document, I will ask you to sign the agreement, stating that you have understood the information contained here. When you sign this document, it will represent an agreement between us. Please ask if you have any questions about this document or the therapy process, now or in the future.

My Qualifications as a Psychotherapist

I have undergone graduate counseling training at Richmont Graduate University (formerly Psychological Studies Institute) in Atlanta, Georgia, and have obtained my Masters of Arts in Professional Counseling. I have passed the National Counselor Exam, required for full licensure in the state of Missouri, and have my LPC. In addition to my Masters degree, I have a Bachelor of Science in Music Education from the Pennsylvania State University. I have found that my varied training in counseling and the creative arts provides me a unique vantage point from which to approach therapy. Having empirical knowledge about "what works" in counseling helps me move clients along therapeutically, while maintaining a more holistic lens I look for the ways that body, mind, and spirit work together for health.

The Benefits and Risks of Psychotherapy

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. 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). This law insures the confidentiality of all electronic transmission of information about you. If ever we have agreed that I would transmit information about you electronically, it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

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. Communications between client and counselor are confidential and will not be revealed **unless required by law** such as in situations of:

- **Child or elderly abuse:** 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 Child Protective Services within 48 hours and Adult Protective Services.
- **Threats of physical harm to self:** If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
- **Threats of physical harm to others:** 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.
- **Subpoena of a court:** If you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called "privilege' and it is your choice to prevent me from testifying or allow me to do so. It is conceivable, however, that in some situations a judge or a court may require me to testify regardless of your non-consent.

Finally, I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Fees and Cancellation Policies

Our first few sessions are evaluation times for both of us. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Standard fee applies for these sessions.

If psychotherapy is begun, we will schedule sessions at the50-minute session per week at a time we agree on. My fee for a 50-minute session is $100. Full payment is due at the end of session, and may be paid by cash, or by credit/debit card. Unless otherwise agreed upon, if fees are not paid for two sessions, no further sessions will be scheduled until account is brought up to date.

Once an appointment is scheduled, you will be expected to pay for it unless you provide **24 hours advance notice** of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control.

It is my desire that no person be denied counseling services due to a lack of financial resources. If you have a need, please speak with me during your first counseling appointment. I have a limited number of slots available for clients on a sliding scale basis and I am happy to work with you to make therapy possible for you with your current financial resources. I can also provide referrals to lower-cost therapy resources that may be options for you.

Contacting Me

The number you can use to contact me is 816.533.4616. I am often not immediately available by telephone. When I am unavailable, my telephone is answered by a confidential voice mailbox that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

If you are unable to reach me and **feel that you can't wait for me to return your call, contact your family physician, call 911, or visit the nearest emergency room** and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CENTER FOR HEALING, LLC
Abigail E. Foard, MA, LPC, NCC
20 W 9th St., Ste 601
Kansas City, MO 64105
Phone: 816.533.4616 email: abigail@thehoperoomkc.com

Your signature below indicates that you have read the information in the **Informed Consent** document and agree to abide by its terms during our professional relationship.

Client Name: _____

Client Signature: _____ Date: _____
Client, or parent/ guardian acting for client

CENTER FOR HEALING, LLC
Abigail E. Foard, MA, LPC, NCC/ The Hope Room LLC
20 W 9th St., Ste 601
Kansas City, MO 64105
Phone: 816.533.4616 email: abigail@thehoperoomkc.com

Today's Date: _____

Identifying/Contact Information:

Name: _____Birthdate: _____Age:_____ Gender: M F

Address: _____

County: _____ Email Address: _____

Telephone: (H)_____(C)_____(W) _____

Presently living with: _____

How did you hear about us?: _____

May we contact this person to thank them for the referral? Yes _____ No _____ Not Applicable _____

Emergency Contact: _____Phone: _____

Current Situation:

Briefly describe the issue that prompted you to seek counseling at this time: _____

_____

_____

_____

Have there been times when this issue got better or disappeared? Yes _____No _____

If yes, when? _____

What do you think helped? _____

_____

Were there times when this issue was especially bad? _____

_____

Are there other people who play a major role in causing problems or in helping you cope with problems?

Yes_____ No_____ Explain: _____

_____

Does anyone in your family have concerns about the way anger is handled? _____

Has your partner ever pushed, shoved or hit you? _____ Is there anything else that you believe might be important for your counselor to know at this time? _____

_____

Marital/ Family Status (Check One):

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name: _____ How long have you been married? _____

Previous marriages? _____ When/ for how long? _____

Reason for divorce? _____

Children's Names:	Ages:	Quality of Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Background:

Father's Name: _____ Age_____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school:_____ Occupation _____

Any medical, psychiatric or substance abuse problems that you know of? _____

_____

Quality of relationship currently? _____

Quality of relationship in childhood? _____

Mother's Name: _____ Age_____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school:_____ Occupation _____

Any medical, psychiatric or substance abuse problems that you know of? _____

_____

Quality of relationship currently? _____

Quality of relationship in childhood? _____

Parents were: Married (how long?) _____ Divorced (how old were you?) _____ Not Married _____

Relationship with stepparents if applicable? _____

_____

Sibling's Names:	Ages:	Quality of Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other noteworthy childhood relationships? Explain: _____

_____

Significant childhood events (divorce, deaths, abuse, sickness, traumas, moving etc.) _____

_____

_____

_____

Education:

Years of education completed: _____

Degrees received: _____

Specialized training or trade school: _____

Do you have any learning or developmental disabilities? Please specify: _____

_____

Do you have any background/experiences in the military? ____ Describe briefly _____

_____

Occupation:

Primary place of work: _____ Position: _____

How long have you worked there? _____ Describe the nature of your work: _____

_____

Do you find this work satisfying? _____

Number of hours work per week: _____

Spiritual Background:

Do you regularly attend religious services? Yes ____ No _____ If so, where? _____

How would you characterize your current relationship with God? _____

_____

Describe any relationships that you have presently that are supportive and encouraging for you spiritually:

_____

_____

Medical History:

Describe any physical problems that require medication or physical care: _____

_____

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult your primary care physician? _____

Who is your primary care physician? (Name/Address) _____

Other physicians whose care you regularly receive: _____

_____

Are you currently taking any prescription medication? Yes_____ No_____

Please list your medications here:

Name	Dosage:	For what condition:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug/Alcohol History:

Have you recently been using alcohol or other drugs? If so, describe: _____

_____

Have you had any problem in the following areas related to your substance use? If so, please mark:

Family _____ Friends/social: _____ Employment: _____ Financial: _____ Health: _____ Legal: _____

Other: _____

Describe your view of your substance use:

_____ Not a problem

_____ Becoming a problem

_____ A severe problem

Have you ever attended:

_____ 12 step meetings

_____ Treatment program

_____ Addiction therapy

Longest period of sobriety and when: _____

How did you stay clean/sober? _____

_____

_____

Counseling History:

Have you had previous counseling/therapy? Yes _____ No_____

If yes, when?_____ For how long? _____ For what condition: _____

With Whom? (Name/ Address) _____

Have you ever been hospitalized for a psychiatric condition? Yes_____ No_____ If yes, please describe briefly: _____

_____

What are your current supports and resources? _____

_____

What are the goals you hope to reach through counseling? _____

_____

Current Concerns

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate each item.

0 1 2 3 4 5 6 7 8 9 10

No concern **Moderate concern** **Extreme concern**

_____Abuse victim
_____Anger/temper
_____Anxiety
_____Aggression/ Violence
_____Attention/ Concentration
_____Bitterness
_____Compulsions
_____Confusion
_____Depression
_____Divorce/ Separation
_____Eating difficulties
_____Education
_____Family problems
_____Fearfulness
_____Financial problems
_____Grief/loss
_____Hallucinations
_____Impulsiveness
_____Marital problems
_____Mood swings
_____Personality conflicts
_____Physical problems
_____Problems in relationships
_____Problems with children
_____Problems with parents
_____Resentment
_____Self-harming behavior
_____Sleeping problems
_____Sexual concerns
_____Spiritual concerns
_____Stress
_____Thoughts of suicide
_____Tormenting thoughts
_____Trouble making decisions
_____Unhappy most of the time
_____Use of alcohol by self
_____Use of alcohol by family member
_____Use of drugs by self
_____Use of drugs by family member
_____Other addiction
_____Work
_____Worry
_____Other (please specify)_____
_____

PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is

2. I worry about

3. What I do best is

4. Sometimes I feel guilty about

5. What makes me angry is

6. My biggest mistakes were

7. My job

8. What makes me nervous is

9. My personality would be better if

10. I often felt that mother

11. Jesus Christ is

12. My temper

13. My childhood

14. Prayer is

15. My biggest disappointment

16. To me, sex is

17. I would be better liked if

18. If often felt that father

19. God to me is

20. My children (child)

21. Women are

22. What hurts me most is

23. My biggest problem is

24. Men are

CENTER FOR HEALING, LLC
Abigail E. Foard, MA, LPC, NCC/ The Hope Room LLC
20 W 9th St., Ste 601
Kansas City, MO 64105
Phone: 816.533.4616 email: abigail@thehoperoomkc.com

NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transmission rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with notification of the privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. The **NOTICE FORM: What You Should Know About Confidentiality** is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, I am required to secure your signature indicating you have been given the opportunity to receive a copy of the **NOTICE FORM: What You Should Know About Confidentiality and the handling of your confidential health information.**

I have reviewed a copy of NOTICE FORM: What You Should Know About Confidentiality, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may, at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates that I have received a copy.

_____ _____

Printed name of client(s) Printed name of parent/guardian

_____ _____

Signature of client, or parent/guardian Date

(The signature of the custodial parent or guardian is required for clients under 18 years of age.)

CENTER FOR HEALING, LLC
Abigail E. Foard, MA, LPC, NCC/ The Hope Room LLC
20 W 9th St., Ste 601
Kansas City, MO 64105
Phone: 816.533.4616 email: abigail@thehoperoomkc.com

WHAT YOU SHOULD KNOW ABOUT CONFIDENTIALITY AND THE HANDLING OF YOUR CONFIDENTIAL HEALTH INFORMATION

Notice of Policies and Practices to Protect the Privacy of Your Health Information: This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations
Your counselor may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- **"Treatment, Payment and Health Care Operations"**
    - **Treatment** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another counselor.
    - **Payment** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose you PHI to your health insurer or obtain reimbursement for your health care or to determine eligibility or coverage.
    - **Health care operations** are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
    - **"Use"** applies only to activities within this clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
    - **"Disclosure"** applies to activities outside of this clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
Your counselor may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An **"authorization"** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the counselor is asked for information for purposes outside of treatment, payment or health care operations, he/she will obtain an authorization from you before releasing information. He/she will also need to obtain an authorization before releasing your Psychotherapy Notes. **"Psychotherapy Notes"** are notes your counselor has made about your conversations during a private, group, joint or family counseling session, which have been separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) the counselor or his/her representatives have relied on that authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse –** If your counselor has reasonable cause to believe that a child has been abused, he/she must report that belief to the appropriate authority.
- **Adult and Domestic Abuse** – If your counselor has reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, he/she must report that belief to the appropriate authority.
- **Health oversight activities –** If your counselor is the subject of an inquiry by the Georgia Composite Board of Professional Counselors, Marriage and Family Therapists, and Social Workers, protected health information regarding you may be disclosed in proceedings before the Board.

- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made about the counseling services provided to you by an intern or the records thereof, such information is not privileged under state law, and may be released subject to a court order. An effort will be made to inform you in advance if this is the case.
- **Serious Threat to Health or Safety** – If your counselor determines, or pursuant to the standards of his/her intended profession should determine, that you present a serious danger of violence to yourself or another, he/she may disclose information in order to provide protection against such danger for you or the intended victim.
- **Worker's Compensation** – Your counselor may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Counselor Duties

Patient Rights:

- **Rights to Request Restrictions** – You have the right to request restrictions on certain uses and disclosure of PHI. However, your counselor is not required to agree to a restriction you request.
- **Right to receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a counselor. On your request, the counseling center will send your bills to another address.)
- **Right to Inspect and Copy –** You have the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used by your counselor to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, your counselor or a designated agent of the counseling center will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your counselor or a designated agent may deny your request. On your request, you counselor or a designated agent will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. On your request, your counselor or a designated agent will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

Duties:

- The counseling center is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- The administration of the counseling center reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, it is required that the center abides by the terms currently in effect.
- If these policies and procedures are revised, you will be notified by mail at your last known address.

Complaints:

If you are concerned that your counselor or this counseling center has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Abigail Foard at 816.533.4616.

You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

IV. Effective Date, Restrictions and Changes to Privacy Policy

This business reserves the right to change the terms of this notice and to make the new notice provision effective for all PHI that it maintains. You will be provided with a revised notice by standard mail.