Mickey Simpson, L.S.C.S.W./L.C.S.W.

8010 State Line Road
Suite #101
Prairie Village, KS 66208
816-305-8830

DEAR NEW CLIENT,

I look forward to working with you. The following information will probably answer some questions you already have and will let you know my policies.

Appointments
Sessions are fifty minutes in length. Your fee covers this time as well as planning and administrative time for your sessions.

Fees and Billing
If you are using insurance, my fee and your copay are based on the terms of your insurance plan. Insurance will be filed weekly. You may also pay privately for services. All case management services are private pay and not billed through insurance. Cafeteria plans such as a Health Savings Account may also be utilized. Examples of this service include yet are not limited to, requested consultation between sessions, requested documentation such letters and forms for disability etc. Brief questions (5 minutes or less) or scheduling issues are no extra fee. Payment is appreciated at the time of your session or when you receive an explanation of benefits from your insurance company.

Emergencies
I have a 24-hour pager that alerts me to any emergency a client may have. You will need to call 816-840-7104 and leave your voice message and a number where you can be reached. Your call will be returned as soon as possible. In the event that I cannot be reached, please go to a hospital emergency room. Be aware that your call may interrupt the session of another client, so please limit using this option for true emergencies. All other non-emergency concerns can be addressed at the 816-305-8830 voicemail number.

Cancellations
You can expect to be charged for any session canceled with less than a twenty-four hour notice. If you are running late for an appointment and have not contacted me, I will wait 20 minutes before I consider the appointment canceled.

Case Records
Your records are kept for 7 years. Files are closed after three months of inactivity. You may reopen your file by scheduling an appointment. At some later date should you decide to use your records for some legal matter, please be aware that they may not be useful for legal purpose's.

Please sign both copies of this form and keep one for your records. I hope that therapy will be a positive and helpful experience for you.

THERAPIST COPY

Signature____ Date________________

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CLIENT COPY

Signature____ Date________________

Empower Counseling Services Inc's   HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize Mickey Simpson LSCSW/LCSW to use and disclose the protected health information described below to __________________________________.(person or place)

This Authorization for release of information covers the period of healthcare from:

___/___/___ to ___/___/___ **OR** all past, present, and future periods ___/___/___

I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment or alcohol or drug abuse).

OR

I authorize my complete health record with exception of the following

__ Mental health records

__ Communicable diseases 9 including HIV and AIDS

__ Alcohol/ drug abuse treatment

__ Other (specify please):____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, disability and or legal requests as I may direct. The authorization will be in force and effect until __________________ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of client or personal representative

____

Printed name of client or personal representative AND his or her relationship to the client

Date __/ __/ __

PATIENT INFORMATION & REGISTRATION FORM

Date: ______________

Patient Name:

____

Last First Middle Initial

S.S.#_________________________ D.O.B.______________ Age:________ Sex:____

Address:

____

City/County/State/Zip:

____

Email Address: ______________________________

Cell Phone: (___)________________ Home Phone: (___)_______________
Work Phone: (___)_______________

Employer: ___________________________ Occupation:______________________________

Other Family Members at Home:
Name Age Relationship

____

____

Current Medical Physician:

____

Medication currently taking:

____

In case of emergency, please notify: ________________________ Relationship: ___________
Address: ____ Phone: ________________

Reason for seeking counseling today:

____

Are you currently seeing any other professional about this?

____

Referred by: ____________________________

In the event of an emergency during which Mickey Simpson, LSCSW/LCSW is unavailable, I understand that I am to report to the nearest emergency room for services.

Signed: _______________________________________ Date: _________________________

EMPOWER COUNSELING SERVICES PAYMENT AND CANCELATION POLICY

A policy is in place for all clients that utilize the services of Mickey Simpson, L.S.C.S.W./L.C.S.W..

All clients must have on file a current credit card (MasterCard, Visa, and or Discover) that will be billed immediately for internet, telephonic, private pay in office counseling, and requested case management. In office, insurance using clients, will pay copays, deductibles if applicable, and case management services via cc too. Regardless of type of service be prepared to show a form of ID and your credit card when selecting a payment type. The cc MUST be in your name unless the owner of the cc has signed documentation and given permission for the client to utilize it for services rendered. This is to ensure financial safety for you and Empower Counseling. If you decide to change or use a different cc card simply inform your counselor and changes will be made. Any chargeback fees due to changes in payment type go directly to the client. This doesn't apply to errors or refunds ECSI would ever need to make, the client of course would not have to pay for our error. When a client is charged for any service, a monthly receipt of payment will be sent so you are aware of what you paid for and when. Any questions or concerns regarding your bill can go directly to Mickey @ 816-305-8830 or her biller, Brandy @ 913-378-2331. If an error has been made it will be addressed that day. As with any credit card charge reversals it may take 3 to 4 business days to return funds to your account. If an immediate payment regarding OUR error is needed a check will be sent directly to the client upon request or the client may opt to pick it up at the office in Prairie Village, KS.

Mickey has utilized the services of a credit card processing company called Professional Charges since 2000, and has never had ANY problems. When you receive your monthly bill it will state profcharges.com, out of California. So don't be alarmed and think your card has been compromised. If Mickey or Brandy can't fix any concern you have feel free to contact professional Charges directly @ 818- 240-8295. Note, infrequently people forget about extra services they requested and upon

asking or reviewing their monthly statement from Empower Counseling Services closely will see what service was provided and when.

If your insurance provider refuses to pay with in 90 days you will be responsible for those charges. I will provide you with proof of payment so that you can continue the process with your carrier. I will bill you at my contracted rate, not my hourly rate.

It is up to the client to know if they have a deductible or what their copay is. In order for an individual to receive payment on insurance claims you must first meet/pay your full deductible. I then report your payment which signals your carrier to start paying the claims.

No shows and non- insurance covered services will be billed within 24 hours. No shows are $125.00 per missed session as that time was held especially for you. Please contact your counselor directly and cancel 24 hours prior to your appointment. If life happens, and you can't make your appointment contact Mickey Simpson @ 816-305-8830 as soon as you can BEFORE your appointment time via text or voicemail, exceptions may disregard the fee or reduce it. Please leave your name and appointment time you will need to miss. If this becomes a repetitive concern Empower Counseling has the right to end our working relationship.

Any and all inappropriate verbal, emotional, sexual or physical misuse of Empower Counseling Services will be met with immediate termination of services of any type. Your cc will still be charged and behavior documented. This is a legitimate site to be used for real mental health concerns.

In order for treatment with Ms. Simpson, L.S.C.S.W./L.C.S.W. of Empower Counseling Services, you will need to sign this agreement.

Date: ____________________________________

Name: ___________________________________

Credit/Debit Card Payment Consent Form

Client Name ____

Print Last *First* *Middle Initial*

Name on Card if different ____

I authorize Mickey Simpson, LSCSW/LCSW and ProfessionalCharges.com to charge my credit/debit card for professional services for professional services as follows:

_________ Counseling services private pay regardless of venue.

_________ Case Management consults or email that occur outside of our scheduled time. (Including requested documentation).

_________ Copays/Deductibles

_________ No Shows Cancelation fee of $125.00

Type of Card: VISA ___ MasterCard ___Discover_______ Exp. Date __________

Card Number ________ - ________ - ________ - ________ CVV Number ______

Card Holder's Billing Address for Monthly Card Statements

____

Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature ____________________________ Date ____ /____ /___

Michelle "Mickey" Simpson, L.S.C.S.W./L.C.S.W.
8010 State Line Road
Suite #101
Prairie Village, KS 66208
816-305-8830

As a client of mine, I want you to be informed of your rights and the limits of confidentiality. The confidentiality of personal information shared with me, your therapist is the cornerstone of a good counseling relationship. Only in this way can a client feel free to work with a therapist to discuss and explore problems and arrive at solutions. In most circumstances information shared is considered privileged communication and will not be shared with anyone, unless the client provides a written release to do so.

There are, however, some circumstances which require the disclosure of information. They are as follows:

1. When mandated by state and federal law, i.e. child abuse/neglect;
2. When specifically ordered by a court of law;
3. When there is serious threat of physical harm to self or another person (i.e., suicidal or homicidal)
4. For the purpose of professional supervision.
5. When insurance coverage is utilized it is considered consent on the insured's part that diagnosis and treatment plans and issues may be discussed by the therapist with your insurance company in order to facilitate insurance claim filling or case management with your insurance company.
6. In the event there is an outstanding balance for which payment has not been made for a period of three months, the account will be turned over to a collection agency.

If it becomes necessary to release information, it will be made in such a way as to protest as much confidentiality as possible.

Acknowledgement

I, ____________________________, hereby acknowledge that I have read and understand the above Statement of Confidentiality, including, the provisions of the statement addressing the extent to which my therapist is permitted to disclose information about me. I give consent for my case to be reviewed by a licensed therapist for the purpose of supervision. Failure to sign this agreement disengages treatment immediately.

_______________________________	__________________________
Client	Date
_______________________________	__________________________
Therapist/Witness	Date

Communication Release

By initialing and dating the following communication options you give permission to the staff of Empower Counseling Services to contact you in various ways that meet your needs. If open to it, texting is a quick way to get fast information to your counselor.

- Home phone
  Initial _____ Date _________
- Cell phone
  Initial _____ Date _________
- Text messaging
  Initial _____ Date _________
- Email
  Initial _____ Date _________
- HIPAA secure internet for video therapy
  Initial _____ Date _________

Print your name ____

Sign your name ____

Date ___________________

Consent for Treatment

I, ____________________________, apply for counseling services with Mickey Simpson, licensed specialist clinical social worker. In making this application, I consent to assessment for the purpose of developing a treatment plan based on my needs and goals. Although I am voluntarily applying for services with Mickey Simpson, L.S.C.S.W./L.C.S.W., I agree to participate in services offered to the best of my ability.

Based on assessment and mental status, I understand that Mickey Simpson, L.S.C.S.W./L.C.S.W., may recommend additional mental health or substance abuse treatment to help me cope with the stresses of my situation. In an effort to do good and not harm, I understand that my therapist may need to refer me if she is somehow not qualified to help.

I understand that in receiving services from Mickey Simpson, L.S.C.S.W./L.C.S.W., I am a collaborator in my treatment and must work to help myself. I am the one with the power to make treatment successful.

The undersigned understands that he/she has the right to:

1. Be informed of and to participate in the selection of treatment services.
2. Receive a copy of this consent and,
3. Withdraw this consent at any time.
4. Be referred to another professional if requested.
5. Any inactivity for more than 90 days and the file will be closed.
6. To receive humane care and treatment.
7. To be treated with dignity and respect.
8. To be free from verbal, physical, or sexual abuse.
9. To have records kept confidential, unless in a medical emergency, in danger of harming myself/another, or if subpoenaed.
10. To have records and documents explained.
11. To confidentiality within those whom review my file for treatment purposes.

Date: __________________

Signature of patient: ____

Signature of parent, legal guardian, or conservator:

____

Signature of Witness: ____

Medical History

Client Name: ____ DOB: ______________
Family Physician: ______________________ Date of last full physical: ______________

Are you currently receiving medical treatment for a specific condition(s)? Yes___ No___
If yes, please list condition(s):____

Please list any medications you are taking and the dosage if known:
____
____

Are you allergic to any medication? Yes_____ No_____ What? _____
Are you pregnant? Yes_____No_____ Maybe______
How many weeks gestation are you? _________
Are you breast feeding a baby? Yes_____No_____

Please list the names and dates of birth of your children:
Name_________________ DOB_______ Name________________ DOB____________
Name_________________ DOB_______ Name________________ DOB____________
Name_________________ DOB_______ Name________________ DOB____________

Do you have a family history of medical problems? Yes____ No_____
If yes, what and who (their relationship to you)? _____________________________________
____

Do you have a family history of depression? ___________ Who? _____________
Suicide? ___________ Who? _____________

Have you ever suffered from any of the following medical problems?

____Alcoholism
____Asthma
____ Bleeding Ulcers
____ Cancer
____ Communicable disease
____ Diabetes
____ Emphysema
____ Epilepsy
____ Erosive gastritis
____ Fatigue
____ Headaches
____ Head Injury
____ Heart Disease
____ Hemophilia
____ Hemorrhage
____ HIV
____ Hypertension
____ Liver disease/jaundice
____ Menopause
____ Menstrual disorders
____ Peptic ulcer disease
____ Pregnancy/birth problems
____ Shortness of breath
____ Stomach problems
____ Stroke
____ Viral hepatitis
____Other

Previous hospitalizations:

1. Medical:____
2. Psychiatric:____

Client signature_______________________________________ Date__________________

PLEASE CHECK ANY OF THE FOLLOWING WHICH ARE CURRENT CONCERNS:

__Moodiness
__Can't concentrate, thoughts racing
__Can't make decisions
__Confused
__Depressed
__Suicidal thoughts
__Anxious, feeling panicky
__Feeling angry
__ Feeling inferior, no self confidence
__Worried, fearful
family
__Sensitive, feelings easily hurt
__Unhappy
__No feelings at all
__Difficulty separating from my family, having my own identity

__Sexual concern
__Shy with people
__Feeling lonely
__Conflict in interpersonal relations- fighting
__Difficulty relating to people, making friends
__Marital concerns
__Problems with children
__Problems with parents,

__Problems with an aging family member
__Dealing with death or loss
__Phobias

__Weight change __gain __loss
__Problems with eating
__Difficulty in sleeping__too much __ too little
__ Lack of energy, tired all the time
__Headaches
__ Overuse of drugs, alcohol, or medication
__ Dizziness, fainting
__Nightmares
__Stomach trouble
__Constipation/diarrhea
__Fast heart beat
__Frequent sweating
__Muscles jumping
__Chronic health problems
__Cold hands, cold feet

__Career indecision
__Difficulties at work
__Concern about finances
__Difficulties with school
__Poor time management

__Increase awareness of my own feelings
__Want to be more assertive
__Develop coping skills
__Clarify personal goals and values
__Have more realistic self expectations
__Eliminate problematic behaviors