

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.

H.I.P.A.A.

(Health Insurance Patient Accountability Act)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

Communication one way or mutually between client and therapist outside the office at 8010 Stateline Road, Ste. 101, Leawood, KS in order to share: appointments, reschedule, resources, treatment programs, diagnosis information and or their general MH Support, is the clients responsibility for their confidentiality. Client is to protect their technology, literature, assignments, confidential locations when they speak or write/text. This covers all venues of communication outside of the office session. (i.e.: mail, email, text, phone, and or video communication)

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protective Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PH in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PH.

We are required by law to maintain the privacy pf PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in the office, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment- Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related

services. This includes consultation with clinical supervisors or other team members. We may disclose PHI to any other consultant only with your authorization.

For Payment- We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purpose of collection.

For Health Care Operations- We may use or disclose, as needed your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law- Under the law, we must make disclosures of your PHI to you upon request. In addition, we must make disclosures to the Secretary of Department of Health and Human Services for the purpose of investigating or determining our compliance with requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPPA without an authorization.

Abuse and Neglect

Judicial and Administration Proceedings

Deceased Persons

Emergencies

Family Involvement in Care

Health Oversight

Law Enforcement

National Security

Public Safety (Duty to Warn)

Suicidality

Without Authorization- Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission - We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization- Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at:

Mickey Simpson LSCSW, LCSW
Empower Counseling Services, Inc.
8010 Stateline Road, Ste. 101
Leawood, KS 66208
(816) 305-8830

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based for copies.

- **Right to Amend.** If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree about the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Mickey Simpson LCSW, LCSW, Empower Counseling Services, Inc., 8010 Stateline Road, Ste. 101, Leawood, KS 66208, (816) 305-8830 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is February 15th, 2019

_____	_____
(Print Name)	(Date)
_____	_____
(Signature)	(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: _____

INSURANCE INFORMATION

Responsible Person/Subscriber:

Name: Last First Middle Initial

D.O.B.: S.S. #:

Address: Phone# ()

Employer: Address:

Relationship to Patient:

I.D. #: Group #:

Insurance Co/Managed Care Co.:

Phone #:

Address:

Medicare: Yes No #

Medicaid: Yes No #

Do you have a second insurer? Yes No

Name: ID#:

I authorize assignment of insurance benefits and payment to: Mickey Simpson LSCW, LSCSW for covered expenses.

Signature

I authorize the release of any medical information necessary to process my insurance claim.

Signature

I understand that I will be responsible for any charges not covered by insurance, regardless of the insurance policy. I agree to give 24 hours notice if I am unable to make an appointment, and I understand that I will be charged for missed sessions if I do not provide such notice.

Signature: Date:

EMPOWER COUNSELING SERVICES PAYMENT AND CANCELTION 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 within 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, LCSW/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 Cancellation 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 protect 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 ___ Fatigue ___ Menopause ___ Other

___ Asthma ___ Headaches ___ Menstrual disorders

___ Bleeding Ulcers ___ Head Injury ___ Peptic ulcer disease

___ Cancer ___ Heart Disease ___ Pregnancy/birth problems

___ Communicable disease ___ Hemophilia ___ Shortness of breath

___ Diabetes ___ Hemorrhage ___ Stomach problems

___ Emphysema ___ HIV ___ Stroke

___ Epilepsy ___ Hypertension ___ Viral hepatitis

___ Erosive gastritis ___ Liver disease/jaundice

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, family
- 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