Cedar Rapids Counseling &
Psychotherapy Group, LLP
www.crcounseling.net

4403 1st Ave. SE Ste. 309
Cedar Rapids, IA 52402
319-362-0632 ext. 7

AGREEMENT FOR SERVICES

Cedar Rapids Counseling & Psychotherapy Group (CRCPG) consists of two Licensed Independent Social Workers: Alexandria Carey, LISW and Penny Freeman, LISW. Their office is located at 4403 First Ave. SE, Suite 309, Cedar Rapids, IA, 52402-3221. The following agreement for services pertains to the practices of *Penny Freeman, LISW.*

Therapy Fees, Billing and Payment

Fees:	Intake session(s)	$170	45 minute session	$125
	Family/Couples session	$130	60 minute session	$156

Health Insurance: If you would like to use your health insurance for therapy, I will gladly submit claims to your health insurance company (HIC) for payment. It is always wise to ask your HIC about the following: (1) if psychotherapy is a covered benefit, (2) if I am an approved provider, (3) the amount of your co-payment, (4) if your psychotherapy is subject to a deductible, and (5) if you require pre-authorization for therapy. You will be asked to pay your entire co-payment at each session. If your HIC does not cover your therapy as you'd expected, you will be responsible for the entire amount. If you encounter financial difficulties, please notify me so we can discuss your concerns. There are a few practices in the area that offer a sliding fee scale.

Diagnosis Code: Please know that if you use your HIC to provide reimbursement for your mental health treatment, they require you to have a diagnosable medical condition (i.e., depression, anxiety, difficulty adjusting to a life event), and I am required to provide that diagnosis code to your HIC when filing your insurance claim. Please feel free to discuss this requirement with me at any time.

Private Pay: Please notify me if you do not have health insurance coverage and/or would prefer to pay out of pocket. You will be asked to provide payment at each session.

Emergencies

My office hours are stated on my voice mail message. I do not have an answering service to attend to mental health emergencies outside of my normal business hours. If you are having an emergency when I am out of the office, please listen to the options I have provided you on my individual voice mail message, i.e., call your family doctor, call Foundation Two Crisis Center at 319-362-2174, or go to the hospital emergency room.

Couples Counseling

When I work with a couple, I consider your relationship to be the client. During the course of our work, I may see one of you individually for one or more sessions or for part of a session. These sessions should be viewed as part of the work that I am doing with the couple unless otherwise indicated. Please know that anything we discuss when your partner is not present may be disclosed to them if, in my best judgment, doing so is necessary to effectively help your relationship. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually. This "no secrets" policy is intended to allow me to continue to treat the couple by preventing, to the extent possible, a conflict of interest to arise. Other than that, I will not disclose confidential information about your treatment to anyone else unless all persons who participate in the treatment provide permission to release such information.

Services Not Provided

Legal: If you are involved in any type of legal proceedings, please note that I do not provide any professional assessments, consultations, or opinions in a court of law. If you are or become involved in legal proceedings that would require the

participation of a mental health provider, please notify me so that I can make a referral to another mental health care practice.

Worker's Compensation: I do not provide therapy services if you are filing under your worker's compensation insurance. Please contact your family doctor for an appropriate referral.

PRIVACY PROTECTION

Limits of Confidentiality

It is important that the guidelines regarding your privacy, also known as confidentiality, be well understood before therapy begins. I will review this material with you at our first session but please read this material carefully so that any concerns or questions you have are adequately addressed.

1. The law protects privacy of all communications between patient and therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by Federal and Iowa law. However, in the following situations, no written authorization is required:

- I may occasionally find it helpful to consult with my colleague, Alexandria Carey, LISW about your therapy. During consultation, I will conceal your actual identity, as well as any other identifying information. Ms. Carey is also legally bound to keep any information confidential and we both receive regular training about the rules, regulations, and ethics of confidentiality. If you prefer that I not consult with Ms. Carey, please let me know and I will respect your wishes.

- If you are involved in or contemplating a lawsuit or other legal action, your records may be subject to a court/ administrative order or a subpoena. Please let me know if this is the case as I may be required to release information.

2. There are some situations in which I am legally obligated to break confidentiality. These are situations in which I believe it is necessary to protect your safety or the safety of others. These are typically very unusual circumstances but it is important for you to be fully informed. They are as follows:

- If you communicate an imminent threat of serious physical harm to yourself, including suicide, I may be required to disclose confidential information in order to take protective actions. These actions may include initiating hospitalization, contacting a family physician or psychiatrist, contacting the police for a welfare check, or contacting family members or others who can assist in providing protection.

- If you were to communicate an imminent threat of serious harm to an identifiable victim, I may be legally required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for yourself.

- If I have reasonable cause to believe that you have harmed a child or a dependent adult, I may be required to file a report with the appropriate government agency, most likely the Department of Human Services. Once such a report is filed, I may be required to provide additional information.

If such a situation arises, I will make every effort to discuss it with you before taking any action, and I will limit disclosure to only what is necessary. Protecting your privacy is very important to me, so please feel free to ask me questions at any time.

INFORMED CONSENT

Therapy is a series of conversations between the two of us designed to help you make changes in your life. A positive outcome becomes our mutual responsibility. This begins with your trust and commitment to therapy and my commitment to facilitating your progress. What we work on and how we work in therapy will be driven by your needs and goals, as well as by my professional recommendations.

Potential Benefits and Risks of Therapy: Many variables will contribute to your success in therapy; however, the benefits you experience in therapy are *most related* to how much you are willing to work towards your goals between our sessions. Potential benefits might be improved relationships, less negative thinking, creative problem-solving, reduced depression and anxiety, and/or better adjustment to life changes. The risks associated with therapy are minimal but are usually an important part of growth. Potential risks might be unexpected changes in your relationships, feeling uncomfortable emotions, a temporary increase in symptoms, talking about unpleasant experiences.

Ending Therapy: Ideally, therapy ends when you have made enough progress toward your goals and are feeling satisfied; however, either of us might decide to end therapy for a variety of reasons. I respect your right to seek therapy elsewhere if you do not feel your needs are being met or if we do not seem to be a good "match" in personality or style. In addition, I may realize that I do not have the skill set needed to address your specific concerns. If your life is at risk, or if the life of someone else is at risk, and you choose not to accept and implement recommendations to ensure your safety or the safety or another, I may end your therapy. Missing or cancelling multiple appointments or not paying for services can also be a reason to end therapy. In all of the above examples, I will provide you with referrals to other therapists and/or practices that may be better equipped to meet your needs. If you have any questions about this, please let me know.

AUTHORIZATION FOR THERAPY

_____ I acknowledge that I was given the opportunity to receive and read the "Agreement for Services and Informed Consent." I am aware that I can download a copy from the CRCPG website at www.crcounseling.net.

_____ I acknowledge that I was given the opportunity to receive and read the CRCPG "Notice of Privacy Practices." I can download a copy from the CRCPG website at www.crcounseling.net. I will be provided a paper copy upon request.

Scheduling Reminders: You can receive an appointment reminder via e-mail, text message or a computer-generated voice message to your phone the day before your scheduled appointment. Appointment information is considered "Protected Health Information" under HIPAA. Given the risks associated with electronic transmission, your therapist cannot guarantee your communication will remain confidential, for example, you may allow others to access your cell phone or your e-mail account. By my initials, I am waiving my right to keep this information completely private.

_____ I would like to receive appointment reminders in one of the ways described above.

_____ I do not wish to receive appointment reminders and will remember my appointments on my own.

General Consent for Billing Insurance *(Please place your initial next to **Option A or B. Do not initial both**.)*

_____ A. I authorize my therapist to release protected health information from my clinical record to my EAP, my health insurance company and/or its designated managed care company for the purposes of certification of psychotherapy services and/or billing for payment of those services. I understand that this authorization continues indefinitely unless I revoke it in writing. However, if I revoke this authorization, I understand that any of the above entities retains the right to information in my clinical record prior to the revocation date.

_____ B. I ***do not wish*** to have an insurance company or other third party pay for the psychological services provided to me. I agree to be responsible for payment of all services provided.

Your signature below indicates that you have read the information in these documents and you agree to abide by the terms during the duration of your professional relationship with your therapist.

_____ _____

Patient Signature Date

_____ _____

Patient Signature (for family/couples sessions only) Date

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CLIENT INFORMATION

Today's Date: _____ How/where did you get Penny's name: _____

Client Name:_____
Last First Middle I. Preferred Name

Address: _____
Street/PO Box City State Zip Code

Client Date of Birth: _____ Age: _____ Employer: _____

Cell Phone: _____ May we leave a message? □ Yes □ No

Home Phone: _____ May we leave a message? □ Yes □ No

Work Phone: _____ May we leave a message? □ Yes □ No

INSURANCE INFORMATION If you are covered by one insurance policy, complete part (1) below. If you are covered by two insurance policies, complete parts (1) and (2) below.

(1) Name of PRIMARY Insurance Company:_____

Subscriber Name: _____ DOB: _____ Employer: _____

Policy/ID Number: _____ Group Number: _____ ***(on insurance card)***

Subscriber Address: (*if subscriber lives at different address from client or parent responsible for billing, please complete)*

Street City State Zip Code

(2) Name of SECONDARY Insurance Company:_____

Subscriber Name: _____ DOB: _____ Employer: _____

Policy/ID Number: _____ Group Number: _____*(on insurance card)*

Subscriber Address: (*if subscriber lives at a different address from client or parent responsible for billing, please complete)*

Street City State Zip Code

SPOUSE/SIGNIFICANT OTHER

Name: _____ Phone(s): _____

Marital Status (circle one): **married separated widowed divorced single cohabitating**

EMERGENCY INFORMATION:

In the event of an emergency, who should be contacted? _____

Relationship to client: _____ Phone(s): _____

IF CLIENT IS UNDER AGE 18 OR IN COLLEGE

Mother's Name: _____ Phone(s): _____

Father's Name: _____ Phone(s): _____

Person responsible to pay for services: _____ Relationship to child:_____

Responsible Person's Address: (*if the responsible person lives at a different address from the client, please complete below)*

_____

Street City State Zip Code

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MEDICAL and SOCIAL HISTORY FORM

This form is a way for me to get to know you better and helps with completing your assessment. If there are questions that make you uncomfortable, please talk with me about it.

Name _____ **Today's Date** _____

Symptoms: Please check each concern experienced recently

__Anxiety	__Depression	__Sleep problems	__Thoughts of suicide
__Panic	__Unusual thoughts	__Anger outbursts	__Changes in weight
__Crying spells	__Memory problems	__Sexual problems	__Relationship issues
__Treated unfairly	__Frequent pain	__Low energy	__Concentration
__Restlessness	__Nausea	__Legal difficulties	__Eating Disorder
__Drug use	__Drinking problem	__Boredom	__Hopelessness
__Stress	__Shyness	__Work problems	__Confusion
__Guilt feelings	__Suspicion	__Thoughts of hurting others	__Loneliness
__Compulsions	__Worry	__Difficulty with decisions	__Money problems
__Specific fears	__Mourning	__Physical illness	__Poor motivation
__Feeling abandoned	__Meaninglessness	__Perfectionism	__Unusually sensitive
__Irritability	__Social withdrawal	__Feeling misunderstood	__Mood swings
__Religious concerns	__Disappointment	__Hearing strange voices	__Impulsive
__Feeling inferior	__Irrational thoughts	__Troublesome thoughts	__No concerns

Any additional concerns or symptoms: _____
What stresses or life changes have you experienced recently? _____
_____

Family of Origin

Parent's first names, marital status and ages _____
First names and ages of siblings _____
_____
Describe your family life as you were growing up _____
_____

Current Living Situation

Marital Status: __Never Married __Partnership __Married __Separated __Divorced __Widowed
If not living alone, with whom are you now living? _____
If Married, name of spouse _____ Age _____ Date of Marriage _____
Dates of previous marriage(s) and name(s) of previous spouse(s) _____
_____
Describe your spouse's (partner's) personality _____
_____
Is your present relationship satisfactory? If not, specify what is unsatisfactory_____
_____
Names and ages of your children _____
Do you have special concerns about any of your children?_____

Personal Information

Education Level _____ If you are currently a student, list name of school _____
Current job and length of time there _____
Current job title _____ How many hours per week are you working? _____
If employment problems are a part of your reason for seeking counseling, please specify _____
_____
How do you spent personal time (list hobbies, sports, religious/spiritual activities, etc) _____
_____
How many contacts do you have each month with friends outside of work or school? _____
_____
Who can you talk with about personal feelings or private matters? _____
_____
Personal strengths/important accomplishments _____
_____

Health Information

Previous counseling or inpatient treatment _____
_____
Was that counseling/treatment satisfactory? Why or why not _____
_____
Family members who have been treated for emotional problems _____
_____
Name of Primary Care Physician _____ Psychiatrist, if any _____
When was your last physical? _____
Please list major illnesses, injuries or surgeries _____
_____
How many hours do you sleep in an average night? _____
_____
Are you currently taking any prescription or over-the-counter medications? Please list names along with dosages
_____
_____
List any allergies _____
How many drinks (containing alcohol) do you consume in an average week? _____
Have you ever used illegal drugs or abused prescription drugs? If so, which ones and how often?
_____
_____
Has drinking or drug use ever caused you legal, work or relationship problems? If so, please explain:
_____
_____
Have you ever sought treatment for substance abuse? If so, describe when, where, and what effect it had on your use:
_____
_____
Has anyone in your family had substance abuse problems? If so, please explain: _____
_____
Do you use tobacco/smoke cigarettes? _____ Amount _____
What is your caffeine intake per day?_____

Thank you for taking the time to complete this form.