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## **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**

<u>Fees:</u>	Intake session(s)	\$170	45 minute session	\$125
	Family/Couples session	\$125	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 of 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](http://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](http://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

**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)

	City	State	Zip Code
Street	_____	_____	_____

(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)

	City	State	Zip Code
Street	_____	_____	_____

**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**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Depression          | <input type="checkbox"/> Sleep problems             | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Panic              | <input type="checkbox"/> Unusual thoughts    | <input type="checkbox"/> Anger outbursts            | <input type="checkbox"/> Changes in weight   |
| <input type="checkbox"/> Crying spells      | <input type="checkbox"/> Memory problems     | <input type="checkbox"/> Sexual problems            | <input type="checkbox"/> Relationship issues |
| <input type="checkbox"/> Treated unfairly   | <input type="checkbox"/> Frequent pain       | <input type="checkbox"/> Low energy                 | <input type="checkbox"/> Concentration       |
| <input type="checkbox"/> Restlessness       | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Legal difficulties         | <input type="checkbox"/> Eating Disorder     |
| <input type="checkbox"/> Drug use           | <input type="checkbox"/> Drinking problem    | <input type="checkbox"/> Boredom                    | <input type="checkbox"/> Hopelessness        |
| <input type="checkbox"/> Stress             | <input type="checkbox"/> Shyness             | <input type="checkbox"/> Work problems              | <input type="checkbox"/> Confusion           |
| <input type="checkbox"/> Guilt feelings     | <input type="checkbox"/> Suspicion           | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Loneliness          |
| <input type="checkbox"/> Compulsions        | <input type="checkbox"/> Worry               | <input type="checkbox"/> Difficulty with decisions  | <input type="checkbox"/> Money problems      |
| <input type="checkbox"/> Specific fears     | <input type="checkbox"/> Mourning            | <input type="checkbox"/> Physical illness           | <input type="checkbox"/> Poor motivation     |
| <input type="checkbox"/> Feeling abandoned  | <input type="checkbox"/> Meaninglessness     | <input type="checkbox"/> Perfectionism              | <input type="checkbox"/> Unusually sensitive |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Social withdrawal   | <input type="checkbox"/> Feeling misunderstood      | <input type="checkbox"/> Mood swings         |
| <input type="checkbox"/> Religious concerns | <input type="checkbox"/> Disappointment      | <input type="checkbox"/> Hearing strange voices     | <input type="checkbox"/> Impulsive           |
| <input type="checkbox"/> Feeling inferior   | <input type="checkbox"/> Irrational thoughts | <input type="checkbox"/> Troublesome thoughts       | <input type="checkbox"/> 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.***