Lee Counseling

Reese A. Lee, M.Ed. ICAADC* NBCCH*

Licensed Professional Counselor

Pennsylvania License PC OO1825

Specializing in Individual, Group and Family Counseling

Clinical Hypnotherapy

General Mental Health and Addictions Counseling

*Internationally Certified Advanced Alcohol and Drug Counselor

***National Board of Certified Clinical Hypnotherapists**

Mary U. Lee, Administration/Counselor Assistant

1661 Hardscrabble Road

Munson, PA 16860-9404

Phone 814.343.6098

Email: LeeCounseling@comcast.net

www.leecounseling.net

NOTE: If you are in crisis and the office cannot be reached, contact one of these facilities:

Clearfield-Jefferson Mental Health Crisis Intervention: 800-341-5040

Clearfield Hospital: 814-765-5341

Bright Horizons: 814.768.2137

Centre County Crisis/Suicide Prevention: 800-643-5432

The Meadows: 800-641-7529

Mount Nittany Medical Center: 814-234-6110

Directions (do not hesitate to call if needed)
to 1661 Hardscrabble Road, Munson, PA
(cross streets to Hardscrabble Road are Old Turnpike Road and Colorado Road):

From Interstate 80:

Kylertown Exit 133 (old Exit 21), drive on Route 53 South for three miles. Turn left at the **green MUNSON 2 MILES sign**. Take a right at the first stop sign. Drive to the next stop sign and take another right. Drive to the 6th house on the right from that stop sign. The house is a yellow, 2-story farmhouse with a dark green door and sets close to the road. Parking is available on the paved driveway.

From Philipsburg:

Take Route 53 North 5.4 miles. Turn right just after the **green MUNSON 2 MILES sign.** Take a right at the first stop sign. Drive to the next stop sign and take another right. Drive to the 6th house on the right from that stop sign. The house is a yellow, 2-story farmhouse with a dark green door and sets close to the road. Parking is available on the paved driveway.

At night we light the front arbor in front of the house with white lights and a flood light.

Rules of Therapy

1. Cancellations must be made 24 hours or more in advance, unless you have an emergency. Other people may be waiting for your appointment.
2. If you NO SHOW, that means you do not call 24 hours or more in advance, this will be breaking the rules of therapy. Lee Counseling will terminate therapy with you if this happens three times.
3. Please bring your copay or payment to each session.
3. You need to bring your therapy folder to sessions.
4. You need to do the home exercises agreed upon for your therapy. You cannot make progress, or get well, if you are not willing to commit to working towards that end with your therapist.
5. Any materials loaned to you by Lee Counseling for your therapy are to be returned upon you completion therapy.

_____Date _____

Signature of Client/Legal Guardian:_____Date_____
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

CLIENT INFORMATION

(Please fill out whatever applies to you. If you have been here before, only indicate information that has changed.)

Please Print Clearly

Date _____Client's Social Security #_____Case #_____

Client's First Name_____Last Name_____ MI_____

Address_____City_____ State_____Zip_____

Telephone(Home)_____(Cell)_____

(Email) _____ (Work)_____

Birthdate _____/_____/_____ Age _____Gender _____F _____M _____

Race _____

Name of Spouse/Guardian_____Phone_____

Address _____City _____ State _____ Zip _____

Person Responsible for Payment _____

Soc. Sec. # _____

Signature of Person Responsible for Payment **X**_____

(Must be signed for services to begin)

Calls or emails will be discreet, but please indicate any restrictions:_____

Emergency Information

In case of emergency, contact:

Name (1)_____Relationship _____

Phone_____Work _____

Address _____City _____State _____Zip _____

Name (2)_____Relationship _____

Phone_____Work _____

Address _____City _____State _____Zip _____

Physician _____ Phone _____

Address _____City _____ State _____Zip _____

Psychiatrist _____ Phone _____

Address_____City_____State_____Zip_____

Other Physicians _____Phone _____

Current Medications _____

Allergies _____

If you enter treatment with me, may I tell your medical doctor so that we can coordinate your treatment? Yes_____ No_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____Phone _____ Hrs _____

Spouse: _____Place _____Phone _____Hrs_____

Insurance Information

Primary Insurance _____ Secondary Insurance_____

Phone_____ Phone _____

Contract/ID#_____ Contract/ID# _____

Group/Acct# _____Group/Acct# _____

Subscriber _____Subscriber _____

Subscriber Date of Birth_____Subscriber Date of Birth _____

Client's relationship to Subscriber Client's relationship to Subscriber

___Self___Spouse___Child___Other ___Self___Spouse___Child___Other

Other third-party coverage: _____

Address:_____ City:_____ State:_____ Zip_____:

Phone number: _____ Persons covered:_____

Contact person: _____

Policy holder: _____ Policy number _____

Other provisions: (___) Personal payment amount: $ _____ Terms: _____

Payment method (Insurance and cash clients; deductibles, co-payments, etc.)

___ Check ___ Cash___ Charge card (type) _____ Number: _____

Cardholder's name:_____ Expires: _____

Referral Source

How did you hear of our practice (or from whom)? _____

Address_____City _____State _____ Zip _____Phone_
_____ Relationship to referral source _____

May I have your permission to thank this person for the referral? Yes_____ No_____

Office Use Only: Completed procedures:___ Entered system_____ Date: _____

Confirmed insurance _____ Date:_____ Confirmed with client _____ Date: _____

Personal—Adult (18+)

Client's name: _____ Date: _____

Gender: ___ F _____ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: ____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion _____ Sexual concerns

___ Sleeping problems ___ Addictive behaviors _____ Alcohol/drugs

___ Other mental health concerns (specify): _____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
	_____	_____	___	___	___	

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___

Marital Status (more than one answer may apply)

___ Single

___ Legally married
Length of time: _____

___ Widowed

___ Divorce in process
Length of time: _____

___ Separated
Length of time: _____

___ Annulment

___ Unmarried, living together
Length of time: _____

___ Divorced
Length of time: _____

Length of time: _____ Length of time: _____ Total number of marriages: _____

Assessment of current relationship (if applicable): _____ Good _____ Fair _____ Poor

Parental Information

___ Parents legally married ___ Mother remarried: Number of times: ____

___ Parents have ever been separated ___ Father remarried: Number of times: ____

___ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? _____ Yes _____ No

If Yes, please describe: _____

Has there been history of child abuse? ___ Yes _____ No

If Yes, which type(s)? _____ Sexual ___ Physical _____Verbal

If Yes, the abuse was as a: _____ Victim _____ Perpetrator

Other childhood issues: _____ Neglect ___ Inadequate nutrition _____ Other (please specify): _____

Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower

___ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

___ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? _____ Yes _____ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? ___ Yes _____ No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____ Yes _____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate _ Much

Are you affiliated with a spiritual or religious group? ___ Yes _____ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes _____ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? _____ Yes _____ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes _____ No
If Yes, please describe and indicate the court and hearing/trial dates and charges: _____
_____
Are you presently on probation or parole? ____ Yes _____ No
If Yes, please describe: _____

Past History

Traffic violations: ___ Yes __ No DWI, DUI, etc.:___ Yes __ No
Criminal involvement: _____ Yes _____ No Civil involvement: _____ Yes _____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: ____ Currently enrolled in school? _____ Yes _____ No

___ High school grad/GED
___ Vocational: Number of years: _ Graduated: ___ Yes _____ No Major: _____
___ College: Number of years: _ Graduated: ___ Yes _____ No Major: _____
___ Graduate: Number of years: _ Graduated: ___ Yes _____ No Major: _____
Other training: _____
Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ___ FT __ PT __ Temp __ Laid-off _____ Disabled _____ Retired
___ Social Security _____ Student _____ Other (describe): ___

Military

Military experience? _____ Yes _____ NoCombat experience? __ Yes _____ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

___ AIDS
___ Alcoholism
___ Abdominal pain
___ Abortion
___ Allergies
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bronchitis
___ Bed wetting
___ Cancer
___ Chest pain
___ Chronic pain
___ Colds/Coughs
___ Constipation
___ Chicken Pox
___ Dental problems
___ Diabetes
___ Diarrhea
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual pain
___ Miscarriages
___ Neurological disorders
___ Nausea
___ Nose bleeds
___ Pneumonia
___ Rheumatic Fever
___ Sexually transmitted diseases
___ Sleeping disorders
___ Sore throat
___ Scarlet Fever
___ Sinusitis
___ Smallpox
___ Stroke
___ Sexual problems
___ Tonsillitis
___ Tuberculosis
___ Toothache
___ Thyroid problems
___ Vision problems
___ Vomiting
___ Whooping cough
___ Other (describe): _____
_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Nutrition

_____

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	___ / week	_____	___ No __ Low _ Med _ High
Lunch	___ / week	_____	___ No __ Low _ Med _ High
Dinner	___ / week	_____	___ No __ Low _ Med _ High
Snacks	___ / week	_____	___ No __ Low _ Med _ High

Comments: _____

Current prescribed medications	Dose	Dates		Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ___ Yes _____ No

If Yes, describe: _____

_____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

_____

Family history of medical problems: _____

_____

Please check if there have been any recent changes in the following:

___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

_____

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

_____

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): ____

_____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes __ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? _____ Yes _____ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_____

_____

Does your body temperature change when you drink? ___ Yes _____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ___ Yes _____ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	____	_____	_	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	____	_____	_	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	____	_____	_	_____
Drug/alcohol treatment	___	___	_____	_____	_____

Hospitalizations ___ ___ _____ _____ _____
Involvement with self-help___ ____ _____ _ _____
groups (e.g., AA, Al-Anon,
NA, Overeaters Anonymous)

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression	___ Elevated mood	___ Phobias/fears
___ Alcohol dependence	___ Fatigue	___ Recurring thoughts
___ Anger	___ Gambling	___ Sexual addiction
___ Antisocial behavior	___ Hallucinations	___ Sexual difficulties
___ Anxiety	___ Heart palpitations	___ Sick often
___ Avoiding people	___ High blood pressure	___ Sleeping problems
___ Chest pain	___ Hopelessness	___ Speech problems
___ Cyber addiction	___ Impulsivity	___ Suicidal thoughts
___ Depression	___ Irritability	___ Thoughts disorganized
___ Disorientation	___ Judgment errors	___ Trembling
___ Distractibility	___ Loneliness	___ Withdrawing
___ Dizziness	___ Memory impairment	___ Worrying
___ Drug dependence	___ Mood shifts	___ Other (specify): _____
___ Eating disorder	___ Panic attacks	_____

Briefly discuss how the above symptoms impair your ability to function effectively: ___

_____
_____
_____
_____
_____
_____
_____
_____

Any additional information that would assist us in understanding your concerns or problems: _____

_____
_____
_____
_____
_____
_____
_____

What are your goals for therapy? _____

_____
_____
_____
_____
_____
_____

Do you feel suicidal at this time? _____ Yes _____ No
If Yes, explain: _____
_____

_____

_____

For Staff Use

Therapist's signature/credentials: _____ Date: __/_____/_____

Supervisor's comments: _____

_____

_____ Physical exam: _____ Required _____ Not required

Supervisor's signature/credentials: _____ Date: __/____/_____
(Certifies case assignment, level of care and need for exam)

Adult Checklist of Concerns

Name: _____Date:_____
Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. **(For a child, mark any of these and then complete the "Child Checklist of Characteristics.")**

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

(cont.)

Adult Checklist of Concerns (p. 2 of 2)

- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns . . . ")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:_____

Financial Policy

We at **Lee Counseling** are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy, which provides payment policies and options to all. The financial policy of the practice is designed to clarify the payment policies.

The Person Responsible for Payment of Account is required to sign the form, *Payment Contract for Services,* which explains the fees and collection policies of the practice. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the practice will bill insurance companies with which we have a provider agreement. For other insurance companies and/or other third-party payers, we will provide claim forms. We cannot guarantee benefits or the amounts that will be covered. We cannot be responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the *Person Responsible for Payment of Account* is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The *Person Responsible for Payment* (as noted in the *Payment Contract for Services*) will be financially responsible for payment of such services. The *Person Responsible for Payment of Account* is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 60 days are subject to collections. A 0.5% per month interest rate is charged for accounts over 30 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, for example, if there were previous visits to another mental health provider since January of the current year that occurred prior to the first session at Lee Counseling, Lee Counseling will still collect the deductible amount until the insurance company or third-party provider verifies that it is complete.

All insurance benefits will be assigned to this practice (by insurance company or third-party provider) unless the *Person Responsible for Payment of Account* pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the *Payment Contract for Services*.

Payment methods include check, cash, or the following charge cards: We do not accept credit card at this time.

Clients using charge cards may either use their card at each session or sign a document allowing the practice to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by calling the office.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account:_____ Date: ____/____/_____

Co-responsible party: _____ Date:____/_____/_____

Payment Contract for Services

Name(s):_____Address: _____
City:_____State:_____ Zip:_____

Bill to: Person responsible for payment of account:_____

Address:_____ ___City:_____ State: _____ Zip:_____

Federal Truth in Lending Disclosure Statement for Professional Services

I. Fees for Professional Services

I (we) agree to pay Lee Counseling , hereafter referred to as the practice, a rate of $ 90 per clinical unit (defined as 60 minutes for assessment, testing, and individual, family and relationship counseling). First diagnostic session is $120.

A fee of $45 per person is charged for group counseling. The fee for testing includes scoring and report-writing time.

A fee of $45 is charged for missed appointments or cancellations with less that 24 hours' notice.

II. Clients with Insurance (Deductible and Co-payment Agreement)

This practice has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $____Deductible amount (paid by insured party)

2) Co-payment ____%____ ($ ____/clinical unit) for first ____visits.

3)Co-payment ____%____ ($ ____/clinical unit) up to____visits.

4) The policy limit is ___per year:____annual ____calendar

We suggest you confirm these provisions with the insurance company. The *Person Responsible for Payment of Account* shall make payment for services, which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

III. All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 0.5% per month (6% Annual Percentage Rate) interest charge on all accounts that are not paid within 30 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____Date:_____

Release of Information Authorization to Third Party

I (we) authorize Lee Counseling to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Lee Counseling.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____Date: _____

Person(s) receiving services: _____ Date: _____

Person(s) or guardian(s):_____Date: _____

Recipient's Rights Notification

As a recipient of services at our practice, we would like to inform you of your rights as a client. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a client

1. Complaints. We will investigate complaints you might have.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights. Federal and state laws protect your civil rights.
4. Cultural/spiritual/gender Issues. You may request services from someone with more extensive training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan, or rescind your consent for treatment.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however we may deny access to certain records. We will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/Legal Advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. Your doctor/pharmacist will provide you with information describing any potential risks of medications prescribed that may be needed in the course of your treatment. Lee Counseling does not prescribe medications.
2. Costs of services. We will inform you of how much you will pay for treatment.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our practice.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
5. Policy changes.

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.

2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.

3. We maintain an objective and professional relationship with each client, as will any therapist who may cover for your regular therapist.

4. We respect the rights and views of other mental health professionals.

5. We will appropriately end services or refer clients to other programs when appropriate.

6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.

7. We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

Client's responsibilities

1. You are responsible for your financial obligations to the practice.
2. You are responsible for following the policies of the practice.
3. You are responsible to treat staff and fellow clients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated

If you believe that your client rights have been violated please contact us.

Consent to Treatment and Recipient's Rights

Client_____ Chart #_____

I, _____, the undersigned, affirm that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Lee Counseling, hereafter referred as the practice. Further, I consent to have treatment provided by Reese A. Lee, Licensed Professional Counselor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that either party may discontinue therapy at any time. The practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the psychotherapist.

Non-Voluntary Discharge from Treatment: A client may be terminated from the practice non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, and/or B) the client refuses to comply with the rules agreed upon for therapy, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision or request to re-apply for services at a later date.

Client Notice of Confidentiality: Federal and/or State law and regulations protect the confidentiality of patient records maintained by the practice. Generally, the practice may not say to any person outside the practice that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the practice, against any person who works for the practice, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is the practice's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records, except in the cases of alcoholism and other drug abuse. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for practice evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with Lee Counseling.

_____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Witness_____Date

LEE COUNSELING

1661 Hardscrabble Road • Munson, PA • 16860-9404

Phone: 814-343-6098 • Website: www.leecounseling.net • Email: LeeCounseling@comcast.net

Privacy of Information Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 9-10-15

Our Legal Duties

- State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

- Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.
- Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. **It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent.** Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

- When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

- Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

- If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

In the Event of a Client's Death

- In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

- Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

- Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

- When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the

amount owed, the time-frame, and the name of the clinic or collection source.

- Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information, which may be requested, includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.
- Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.
- In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

- You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $__.25_____ per page, plus postage. You may also request an electronic version of your records.
- You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.
- Most disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require authorization from you.
- Other uses and disclosures not described in the Privacy Notices will be made only with authorization from you.
- You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.
- If you pay for your services out-of-pocket in full, you can ask us not to share that information with your health insurer. We will ask you to sign a paper if you decide to do that.
- You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.
- You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.
- You have the right to know what information in your record has been provided to whom. Request this in writing.
- You may choose someone to act for you if that person has medical power of attorney, or is your legal guardian.
- If you desire a written copy of this notice you may obtain it by requesting it from the Privacy Officer at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the Privacy Officer, Mary U. Lee. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Pennsylvania State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: Lee Counseling, 1661 Hardscrabble Road, Munson, PA 16860-9404

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature:_____Date: _____/_____/_____

Signed by: __client __guardian __personal representative

_____Copy given _____Copy refused