EAP Therapy, LLC
Elisha Klaiber LPCA, CSAT-C, ART Provider

INFORMED CONSENT

By reading and signing below, you acknowledge and agree to participate in mental health services provided by EAP Therapy and Essential Healing IOP, Inc "EHIOP", its employees, and independent contractors. We understand that beginning a therapeutic relationship in a counseling setting may be a new experience and that you may have many questions. We will do our best to answer any questions or concerns you may have during your initial visit. The information below explains processes and other information about policies and procedures, State and Federal Laws, and your rights regarding therapy.

As a Licensed Professional Counselor Associate (LPCA) my goal is to help you live the best life possible. I am trained in Accelerated Resolution Therapy (ART) which is a useful tool for trauma and areas clients feel stuck mentally. I am also trained as a Certified Sex Addiction Therapist Canidate.(CSAT-C). This allows me to work effectively with clients, partners, and families needing help in this area. The candidate (C) indicates that although I have completed the training. I remain under supervision until required hours are met.

Therapy involves a large commitment of time, money, and energy, so you should be careful about the therapist you select. Therapy services are not like services received from a medical doctor. Instead, they call for a very active effort on your part. For example, if you are receiving therapy from me, in order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. If you have questions about my procedures, we should discuss them whenever they arise.

TREATMENT PROCESSES AND DOCUMENTATION

It is the provider's responsibility to keep accurate chart records including assessments, case notes, treatment plans, and progress notes. By signing this agreement, you are consenting to the treatment plan that your provider creates and agree to any goals, objectives, and therapy techniques that may be used during your therapeutic processes.

CONFIDENTIALITY

Confidential information whether discussed in session or your communication with staff members is not disclosed outside of EAP Therapy and/or EHIOP without your written permission with exception to the following: 1. Where you sign a release of information to have specific information shared; 2. Information you disclose about physical, sexual or elder abuse; then, by Kentucky State Law, I have to report this to the Kentucky Department of Children and Family Services; 3. If you disclose you are in danger of harming yourself or others; 4. Diagnosis and dates of service shared with your insurance company to process your claims; 5. Information shared with therapist's clinical supervisor, if applicable; 6. When disclosure is required by law. This includes the reporting required under supervision during the licensing process from LPCA to LPCC and from CSAT-C to CSAT, which I am currently bond to. The specific names of these supervisors will be given upon request.

SESSIONS AND PROFESSIONAL FEES

I typically schedule one 50-60—minute sessions, although some sessions may be longer. An intake session may last 1 ½ hours. Your appointment time is reserved for you. You will be

expected to pay for it unless you provide 24 hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control.

My fee for regular therapy sessions after the initial intake session is $80 per 50-60 minutes, to be paid prior to or day of the session. The fee for initial intake session is $140.00 for individual and $160 for couples. If there are special circumstances you would like for me to consider regarding these fees, you must discuss the circumstance with me prior to the first session. If you miss an appointment without notice or fail to call more than 24 hours in advance, you may be billed $50 for that time.

In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, assessment processing, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all professional time, including preparation and transportation costs rendered by me on your behalf. Due to the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

I accept cash and checks or PayPal. You will be expected to pay prior to or the day of each session, unless we agree otherwise. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve engaging our billing company's services hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. By signing this agreement, you grant permission for me to seek assistance in collecting unpaid fees. To avoid having me use legal means to secure payment, please communicate with me about any concerns that you have regarding your ability to pay.

If you pay by check and it is returned for non-payment/insufficient funds, your account will be assessed a $40.00 fee in addition to original check amount.

INSURANCE BILLING

At this time EAP Therapy does not accept insurance. Should you be a client referral through EHIOP the following applies: If you plan to use insurance to pay for services, claims will be sent to your insurance company through iMAX Medical Billing based on information used at the time of service. Occasionally, insurance information may change or may not be up to date. If for any reason inaccurate information related to deductibles, co-pays, or number of available sessions, etc. is obtained at the time of service, EHIOP (iMAX) will bill you for any additional costs associated with mental health services rendered. Additional services may be denied until your

account balance is brought current. If balances remain unpaid for more than 60 days, your information will be sent to a collection agency. Depending upon the services rendered and the providers who are assigned to your case, our partnering agency may bill your insurance for the services rendered.

CONTACTING ME

Due to my work schedule, I often am not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call as quickly as possible. Calls and/or emails may be returned by myself or a member of EHIOP staff. I do not typically return calls on weekends, during vacations, or on holidays. Reasonable efforts to return calls and/or emails will be made within 24-72 hours. If you are unable to reach me, and you have a critical or emergent need that cannot wait, please contact your family physician or 911.

Your signature on this document indicates that you understand and agree to the information provided for the duration of your treatment. If you are seeking child or family therapy, your signature also gives permission for you minor children to receive therapy services.

I have read and understood all of the information in this agreement. I have asked any questions and received answers needed. By singing this document I agree to all conditions herein and also hereby give permission for my/our minor children to receive therapy services.

Client Signature: _____Date:_____

Print Name _____

Clinician Signature: _____Date:_____

Print Name _____

MINORS AND PARENTS

I will provide treatment/evaluation to children only with custodial consent to do so. Clients under 17 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents regarding how children's privacy can be honored. Information given to me by your child which involves risk to life, incidences of abuse or neglect, or other unlawful activity will be shared with you as soon as reasonably possible, and, if necessary, appropriate actions taken to aid in the protection of your child and any other potential victim. I will use my clinical judgment to advise you of your child's statements regarding issues outside those stated areas.

Minor signature: _____Date:_____

Print Name _____

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CLIENT RIGHTS

Right to request how we contact you. It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records. You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records. You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records. If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures. You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain. If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

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HIPPA NOTICE OF PRIVACY PRACTICES 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.

EAP Therapy has been and will always be totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes our policies related to the use and disclosure of your healthcare information. Your health information may be used for the purposes of providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT
We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT
Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS
We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Kentucky State Law, we are obligated to report this to the Department of Children and Family Services; If you provide information that informs us that you are in danger of harming yourself or others, we must report this also; Information may be used to remind you of/or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order; Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of pocket and in full.

METHOD OF CONTACT BY OFFICE
We may send you appointment reminders by text message or phone call and leave a voice message. To authorize email, please list email here:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:
I have read and received a copy of the Notice of Privacy Practices and Client Rights document.
Client Signature_____ Date_____
(Parent/Guardian must sign if client is a minor)
Clinician Signature:_____ Date_____

1795 Alysheba Way Ste 1001 Lexington, KY 40509 Phone: 859.595.9913 Fax: 859.353.4200
email: Info@essentialhealingiop.com Web: www.EAPTherapy.com

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HIPAA Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

- ☐ I authorize EAP Therapy, LLC to gather information from, collaborate with, use, and disclose the protected health information described below with:
- ☐ Primary Care Physician_____
- ☐ Emergency Contact_____
- ☐ Partner Agencies- KOI and Essential Healing IOP
- ☐ Dr. Paul Schmidt
- ☐ Mike Rogers
- ☐ Other_____
_____

EFFECTIVE PERIOD

- ☐ all past, present, and future
  OR
- ☐ This authorization for release of information covers the period of healthcare from: _____ to _____.

EXTENT OF AUTHORIZATION

- ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). **OR**
- ☐ I authorize the release of my complete health record with the exception of the following information:
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug tx
  - ☐ Other (please specify):_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to EAP Therapy, LLC. I understand that a revocation is not valid to the extent that EAP Therapy, LLC has acted in reliance on such authorization. This authorization does not expire until I submit a written request. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING PROVIDER OR ORGANIZATION: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for disclosure of this information by the recipient and, if that occurs, federal law may not protect the information.

Client Signature_____ Date_____
(Parent/Guardian must sign if client is a minor)
Clinician Signature:_____ Date_____

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Client Intake Form Date:_____

Name_____Age_____

Address_____City_____State_____Zip Code_____

Phone(H)_____(C)_____(W)_____

DOB_____ Gender_____

SS#_____ Email:_____

How did you hear about my services:_____

Preferred Method of contact:_____

Emergency Contact Name_____

Phone_____ Relationship to Client_____

Primary Care Physician_____Phone_____

If client is a minor name of Legal Guardian_____
Phone_____Relationship to Client_____

Reason for Seeking Services:

Briefly state what problems, symptoms, or complaints have caused you to seek help at this time and to the best of your knowledge, when these began:

PAST & CURRENT MEDICAL CONDITIONS:

DO YOU CURRENTLY SEE A PSYCHIATRIST OR PSYCHOLOGIST ? IF SO , NAME :_____

Previous experiences with counseling or psychiatric treatment:

MEDICATIONS and/or SUPPLEMENTS (CURRENTLY TAKING):

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Symptoms Checklist - Mark only the ones that apply to you currently and note if mild, moderate, or severe and for how Long:

	Check those that apply	**Indicate Mild, Moderate, Severe**	**How long have you experienced symptom**
Depressed Mood			
Crying Spells			
Irritability			
Appetite Issues			
Loss of Interest			
Excessive Worry			
Trouble Concentrating			
Anxiety or Panic			
Trouble Sleeping			
Sleeping too much			
Excessive Energy			
Fatigue			
Racing or Intrusive Thoughts			
Libido Changes			
Substance Use			
Alcohol Use			
Suicidal Thoughts			
Thoughts of Self Harm			
Risky Behavior			
Impulsivity			
Feelings of Dissociation			
Hallucinations			

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Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up: _____

Family History: Mark any below that apply to parents or your extended biological family.

	Relation	Did they receive help
Depression		
Anxiety or Panic		
Bipolar Disorder		
Alcohol Use Problems		
Substance Use Problems		
ADD/ADHD		
Sexual Abuse		
Physical Abuse		
Emotional Abuse		
Marital Difficulties		
Violence		
Suicide or Suicide Attempt		
Schizophrenia		
Mental Retardation		

If applicable, list your siblings and their ages:

_____

_____

Describe your father and your relationship with him:

_____

_____

_____

Describe your mother and your relationship with her:

_____
_____
_____

How old were you when you left home?_____
Has anyone in your immediate family died? Yes ( ) No ( )
If so, who and when?
_____

Have you ever tried to kill or harm yourself before?_____
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts_____
When was the last time you had thoughts of dying? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?_____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____

RECENT STRESSFUL LIFE SITUATIONS (check all that currently apply):

____Recently married	____Legal issues	_____Personal injury, illness
____Retired	____Job loss	_____Bad health
____Recently divorced	____Separated	_____Partner infidelity
____Financial Problems	____Hospitalized	_____Abuse
____Sexual issues	____Current student	_____Relationship breakup
____Changes at school	____Changes at work	_____Issues w/family
____Death of loved one	____Other, Specify:_____	

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect?
Yes ( ) No.( )

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?
_____
If yes, where were you treated and when?
_____
How many days per week do you drink any alcohol? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones?
_____

Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long?

_____
_____

How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____ Other_____

Educational History:
Highest Grade Completed? _____
What is your highest educational level or degree attained_____

Occupational History:
Currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired ( ) Stay-at-home parent
How long in present position_____

What is/was your occupation_____

Have you ever served in the military? _____
If so, what branch and when_____
Honorable discharge ( ) Yes ( ) No Other type discharge:_____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed ( ) Separated ( )
How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Describe your relationship with your spouse or significant other:

_____
_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long?

_____

Do you have children? ( ) Yes ( ) No
If yes, list ages and gender:

_____
_____

Describe your relationship with your children:

_____
_____

List how many currently live with you and ages:

_____
_____

Legal History:
Have you ever been arrested? _____ Do you have any pending legal problems? ____
If yes to either question please
explain:_____
_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, specify and indicate level of involvement: _____

During this time does your involvement make things? ( ) more helpful ( ) more stressful
Brief description of your beliefs:

_____
_____
_____

Is there anything else that you would like me to know?

_____
_____
_____

Signature_____Date_____
(Parent/Guardian must sign if client is a minor)

Print name_____

For Office Use Only:
Reviewed by _____Date _____