# EPKC Child Intake Form

**Date: _____**

Name: _____ DOB: _____

Address: _____

City/State/Zip: _____

Cell phone: _____ Email: _____

Parent or Guardian: _____ Cell No:_____

Parent or Guardian:_____ Cell No:_____

With Whom Does the Child live?_____

What is the Scheduled parenting time?_____

**For Grant Purposes (please indicate below)**

| **Race: Circle** | Caucasian | Black | Hispanic |
|---|---|---|---|
| Asian | American Indian | Bi-Racial | Other |

| **Sex: Circle** | Male | Female | Other: |
|---|---|---|---|

| **Financial:** | Not working | 0-25,000 | 25,001-49,999 | 50,000-69,000 | 70,000 + |
|---|---|---|---|---|---|

| **Primary Insurance** | **Policy Holder Name** | **Policy Holder Date of Birth** | **Plan Name** |
|---|---|---|---|
| * | | | |

**Insurance ID: _____ Policy Group No: _____**

**<u>*(We reserve the right not to accept insurance for high conflict including divorce, modifications)</u>**

| Secondary Insurance: | ID | Group: |
|---|---|---|

### Authorization to Release Information and to Pay Benefits Directly to Provider:

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payments of benefits to be paid directly to the therapist for services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

Parent Initial: _____

Staff Initial: _____

I understand that I am responsible for paying applicable co-payments and co-insurance amounts. Co-payments are due the day and no later than the time of service is rendered. Service will be declined for nonpayment.

Empowering Parents KC (EPKC) will make every effort to inform you of the cost associated with services. However, there are many factors that are beyond our knowledge or control such as your deductible, co-insurance, out of network costs, etc. Therefore, there may be additional costs above and beyond your co-payment. You are advised to contact your insurance company to educate yourself on the total cost of the services received. There may be consultation fees that apply.

I understand it is my responsibility to inform EPKC if my coverage or insurance changes. I am responsible for paying for the services if insurance denies payment or if insurance is termed.

Should there be two parents who are divorced and jointly paying for counseling, the respective parent who brings the child must pay the full fee and be reimbursed by the other party, if joint custody, both parents must agree to the therapy. Therapy will not be conducted without payment made at the time of service.

## Financial Policy:

Providers are committed to providing you with the best possible service. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about fees, the Financial Policy is your responsibility for payment.

All clients must complete the information form and financial policy prior to seeing the therapist. Your insurance provider may have additional forms that they require or request.

Payment is due at the time of service. We accept money orders, debit/credit cards, HSA cards. If you use a credit card, fees will be incurred. If you do not put a credit card on file, payment will be required at the time of service or services will not be provided.

## Cancellations

A 24-hour notice is required for all cancellations. A fee of no less than $100 will be charged for the missed appointment. Insurance companies and your employee assistance programs do not pay for missed appointments. Your appointment time is reserved specifically for you. Policies regarding charging for missed appointments appear herein. Please help us serve you better by keeping to your scheduled appointments. Fees incurred in less than 24 hours may include but not limited to symptoms of Covid, Covid testing, flu, illness, accidents, inclement weather, etc. Fees will be charged to the credit card on file. More than two no shows or least minute cancellations may result in discharge from EPKC services.

### Insufficient Funds

I agree to pay any and all bank fees associated in the event of checks received for insufficient funds. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and for professional services and/or consultation rendered. I have read all of the information herein and have completed the “Client Information” form. I certify that the information provided is true and correct to the best of my knowledge and agree to notify my provider of any changes regarding the above information or other charges that may impact on my treatment. Charges

for NSF will be $50 plus return charges and bank fees. We will assign additional fees for multiple attempts to collect through credit cards, debit cards, as this takes additional time out of our day.

**Consultation and/or Legal Case**

During your divorce or modification, there may be occurrences when the therapist is asking to meet with, contact or write reports or emails. There may be consultation fees associated with your particular case. These fees may apply to the case, Consultations with attorneys or other therapists, co-parent counselors, take us away from our practice and make time for other clients. Often, we work late and at weekends to meet the needs of the clients. The fee for depositions, reports, court testimony, email review/response, phone calls, etc. As a result, there will be a minimum of 4 hours charged for court or depositions. Fees for such services are paid in advance or deposited with your attorney in advance of the required date. Court fees are nonrefundable.

## Empowering Parents KC Professional Fees (*Based on Sliding Fee Scale)

| | |
|---|---|
| Initial Intake | *$150 (without insurance) |
| Individual Psychotherapy | *$125 (without insurance) |
| No show/Late Cancellations | $100 per occurrence |
| Consultations (Court/trial prep, email review/response, phone, etc.) | $150 per hour |
| Court Attendance and Depositions (4 hour minimum) | $400 per hour |
| After Hours calls (past 5pm and weekends) $100 minimum | $150 per hour |
| Response to emails/phone calls (min $50 each) | |

## Empowering Parents Kansas City (EPKC) Fees are sliding fee scale

Empowering Parents KC will provide letters, forms and reports and attend court which must be paid in advance. Court testimony is paid in advance with 4 hour minimum based on current Sliding Fee Scale Fee plus mileage. This is nonrefundable. Any other service is based on the hourly sliding fee scale rate.

## Custody Services

Please note that if you have divorce or custody papers that require both parents to make joint decisions for medical and/or mental health issues then both parents must agree to the treatment of the minor child. Both parents must sign all consents in these circumstances. This may also include a court order for therapy. Failure to notify EPKC will result in immediate discharge from services. Both parents must provide the most current parenting plan prior to the start of services.

## Security of Records

Your treatment and related financial records are kept in a locked file room. Records will not be made available to others without a signed authorization to release the information except where allowed or mandated by law. There is a charge for copies of records, which is in accordance with Missouri State Law of who regulates these fees. We will follow HIPAA Laws and will abide by HIPAA to ensure the safety and security of our clients. You may request access to your records and you understand that it will take 30 days to receive receipt of records, if approved by therapist. If not approved you understand you will

receive notification of same. Records will not be disbursed via email and only provided by client picking up records from EPKC office.

## Security Cameras and Recordings and Confidentiality of phones/Email

EPKC does **not** allow recordings (video or voice) nor cameras in therapy sessions. This includes individual therapy, family therapy, co-parenting, reunification and therapeutically supervised sessions. If you choose to email your therapist from your personal or work email account, please limit the contents to basic issues such as scheduling and cancellations. We will not respond to personal or clinical concerns via regular email or phone text messaging.

## Retention of Records

Treatment and financial records are retained for a period of 7 years following the termination of treatment for adults and until age 28 in the case of minors. If you have been involved in coparenting, records will not be shared without both parties agreeing. Special rules relating to release of treatment records containing information regarding drug and alcohol abuse include: CFR 42, Part 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. A general Release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is prohibited.

## Discharging Clients

Your file may be closed for no-showing for appointments, no contact, nonpayment of fees, lack of progress, dishonesty or treatment interfering behaviors. Therapist will make every effort to contact you either by phone or email to re-engage you or your child in services. If there is a lack of progress it will be discussed with you and the therapist can assist you with a referral to another provider.

## After Hours Emergencies

EPKC is unable to provide 24/7 emergency coverage. You are welcome to attempt to call and if the therapist is available the therapist will respond. If it is life-threatening, you will need to call 911 immediately. If it is urgent and you are unable to reach your therapist, please call the Access Crisis Intervention Line (open 24 hours) at 1-888-279-8188. Business hours do vary but typically are Monday through Friday from 8am – 5pm. Calls to the therapist after hours and on holidays will incur consult fees.

## Authorization to Treat

I give consent to my therapist to provide assessment and therapeutic services to my child, within the scope of their license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem as efficiently as possible. I agree to cooperate with my therapist in this treatment process and to follow through with any medical treatment, as prescribed by the treating physician.

## Social Work Interns

I understand that my services may include a clinical intern sitting in the session. The intern is a Masters Level student. They are focusing on their clinical expertise. The intern is under the supervision of a Licensed Clinical Social Worker. I understand that the intern does not work alone and will be under the

supervision of the LCSW. Inters are observing only and not providing services. Please notify the CEO if you do not wish to have an intern involved. The intern may be sitting in the session with therapist so they are afforded hands-on learning.

## Informed Consent for Assessment and Treatment

I, _____, hereafter designated as the client, request and consent to those services and treatment offered by EPKC. Which may include therapy/counseling, consultation and treatment.

I understand that as a client of EPKC, I may be eligible to receive service including but not limited to outpatient individual and family psychotherapy, couples therapy, consultation, co-parenting, therapeutically supervised visit, reintegration therapy. The type of and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. I understand that the goal of the initial assessment process is to determine the best course of treatment for me. Plans and recommendations for treatment will be discussed with me and I will participate in the planning thereof. Typically, treatment is provided over the course of several weeks or months. Medication services may be recommended and a referral provided.

I understand that all information that I disclose to my mental health service provider is confidential. During the course of treatment, it may be necessary for my mental health service provider to communicate with other providers. I may authorize any discussion with other providers, including but not limited to treatment physicians, case managers, and other necessary individuals for the continuity of the mental health treatment I may receive. I further understand that there are specific and limited exceptions to the types of information that may be disclosed which include the following:

When there is a risk of imminent danger to myself or another person, the clinician is legally and ethically bound to take necessary steps to prevent danger, such as informing law enforcement or others that are in danger.

When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform proper authorities.

When a valid subpoena or court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests; to understand that my medical records will be release pursuant to such court order or subpoena.

I understand that a range of mental health professionals may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Medications may have unwanted side effects. I understand that my active participation and compliance with treatment will be an important factor to achieving a positive outcome from mental health treatment. I understand that EPKC does not guarantee a positive outcome concerning the state of my mental health.

If I have any questions regarding this consent form or about the services offered by EPKC, I should discuss them before signing this consent.

I have read, understood and agree to abide by the provisions thereof. I have been given a copy of the Notice of Privacy Practices, if requested. I have read and understood the above. I consent to participate in the evaluation and treatment offered to me by EPKC and I understand that I may stop treatment at any time. I understand and agree that I must inform EPKC if I decide to stop treatment.

I authorize the release of any medical records or other information necessary to process insurance claims (including Medicaid claims). I also authorize payment of benefits directly to EPKC for services provided. Where applicable.

I have read all of the information herein. I certify that the information provided is true and correct to the best of my knowledge and agree to notify my provider of any changes regarding the above information or other changes that may impact on my treatment. I agree that I have thoroughly read all pages including Authorization to Release Benefits, Financial Policy, Cancellation Policy, Insufficient Funds, Consultation, Professional fees, Custody Servies, Rights and responsibilities, security of Records, Cameras/Recordings, Retention of Records, Discharges, Emergencies and After Hours, Authorization to Treat and confidentiality with Cell phones and emails.

Signature of Client/Guardian_____ Date: _____

Signature of Therapist_____ Date: _____

## Problem List: Current Symptoms:

**1._____**

**2._____**

**3._____**

**4._____**

**5._____**

**Please list below any problems of which you would like the therapist to be aware:**

_____
_____
_____
_____
_____

## EPKC Credit Card Payment Authorization Form

**By signing this form, you give permission to debit the amount for all services you have received, which may include deductible, copays, consultation, court, etc.**

| **Cardholder Name: _____** |
|---|

**Cardholder Address:**

**_____**

**Account Number: _____**

**Expiration Date: _____**

**CVV (3 or 4 digit code) _____**

**I authorize the above-named business to charge the credit/debit card indicated on this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and for the amount indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit/debit card company; so long as the transaction corresponds to the terms indicated on this form. At any time, I can discontinue this card but must do so in writing.**

**Signature: _____**

****Also, any children who will be participating in family therapy may be in individual counseling as well with another provider. There may be consultation fees incurred as a result. Please be aware that costs may be for consultation with attorneys on the case. Fees may also be incurred for meeting with the parents to establish services. If services are for the child the therapist cannot bill insurance for all parents and children as that is a conflict of interest, so some fees may be required for consultation.**

**Please be mindful that while your child is in therapy, other children are not allowed to wander through the building and use the restroom unattended under the age of 12. They have adult supervision at all times.**

**EPKC also honors a No Secrets policy as it relates to your child's therapy and coordination of services with parents and staff.**

**If you have specific questions about any of the above, please email Lisa Erickson at lisaerickson@hushmail.com. We keep phone calls to a minimum due to time constraints. Please be aware if you wish to talk with therapist you will need to schedule, Further, walk-ins and demands to talk with therapist without an appointment may not be acknowledged due to time constraints.**

**Any portion of this intake that is not authentically signed will be returned to you for signature.**

**You are welcome to complete the intake process by stopping in to complete the form in person on your own time between the hours of 8-5, Monday through Friday.**

**We appreciate your business and your understanding of the above.**

**_____ Signature of Parent/Guardian _____Date**

**_____Signature of Clinician/Staff**