HELLO AND WELCOME!

Thank you for allowing us to serve you and your family! We understand that you have choices when it comes to choosing a mental health provider. Thank you for choosing us.

It is with great pleasure that we welcome you to our clinical practice. Our hope is to serve you and/or your family and work toward the best possible outcome you desire. Our services are done with the highest standards and ethics for your care. We love what we do and hope that your experience is nothing less than the best.

You have several rights as a patient. These include the right to know fees, ask questions and to end services at any time. The following paperwork will also inform you of the limits of confidentiality and how your personal health information is used.

The following paperwork must be completed in its entirety for the assessment and following therapy sessions to take place. Your information is confidential within the limits described on the following pages. Keeping your privacy is something we take very seriously. If you need assistance completing some of the questions, we will gladly assist you at your first session. We can assume no responsibility for your case until our first session in person occurs, and documents are signed. We very much look forward to meeting you.

Again, thank you for selecting our practice. We look forward to providing the professional services you expect. If at any time you have an issue that needs my attention, please contact me directly at the correspondence listed below.

Respectfully,
Michael C. Adams, MS, LPCC, CADC
President/Therapist

Please Note: We have two locations now within the same office park at 7000 Houston Rd. Please make sure you are going the right office by seeing which office your therapist is located at:

Suite 11
Kathryn Plymale
Brittany Bundy
Heather Spera
Alissa Lehn

Suite 18
Michael Adams
Bryan Purcell
Bettie Howe
Lindsey Moore
Kristen Gillespie
Rose Grimes
Erik Plymale

For detailed information, please visit our website: **www.northernkentuckycounseling.com**

This information is required before any services are rendered. Thank you for completing this!
Please fill in the appropriate sections, print out and bring with you or complete in written format.

Patient's Last Name:	
Patient's First Name:	
Patient's Middle Initial:	
Patient Goes By (if other than above):	
Date of Birth (mm/dd/yyyy):	
Patient/Responsible Party Social Sec. #	
Patient's Gender:	Female or Male
Patient's Marital Status:	Single Married Other
Patient's Employment Status:	Employed FT Student PT Student Other
Related to accident or workers comp?	No Yes Explain_____
Street Address:	
City:	
State:	
Zip Code:	
Home Phone Number:	Ok to leave messages? Yes No
Second Home Phone (optional):	Yes No
Work Phone Number:	Yes No
Work Extension:	
Cell Phone Number:	Yes No
Second Cell Phone Number (optional):	Yes No
Email Address:	Ok to email you? Yes No
EMERGENCY CONTACT AND #	
Financially Responsible Party Name (If other than client identified on this form).	
Responsible Party Street Address:	
Responsible Party City, State, and Zip:	
What kind of appointment reminder? Please circle only one. (by circling this you are also giving consent to receive this type of communication)	Email (requires email address) Text Message (requires cell phone and carrier) Phone call (requires home phone number) None (no reminder will be sent)
The following below will allow you to access your online account with us, your Therapist or our Administrative Assistant will provide further instructions!	
Username: (15 character max, no spaces, letters and #'s only)	
Password: (10 character max, no spaces, letters and #'s only)	

THE COUNSELING SERVICES OF MICHAEL C. ADAMS & ASSOCIATES, PSC
7000 HOUSTON RD. BLDG. 200, STE. #18 FLORENCE, KY 41042
PHONE: (859) 525-0185 | FAX: (859) 525-8100
ADMIN@NORTHERNKENTUCKYCOUNSELING.COM
WWW.NORTHERNKENTUCKYCOUNSELING.COM

If insurance will be used please fill in this section. **Please Note:** **You are responsible to verify your eligibility and benefits prior to your first session including deductible amounts and need for prior-authorization. Any charges not paid by your insurance company will be your responsibility. (Please see Fee Agreement on Page 5). Use of insurance bound by contract terms.**

Primary Insurance Company:	
Insurance I.D. Number:	
Insurance Group Number:	
Effective Date (mm/dd/yyyy):	
Referring Physician (rarely needed):	
Referring physician NPI (**Tricare only**):	
Patient's relationship to Insured:	Self Spouse Child Other
Insured Name (**Last, First MI**): ** Subscriber is the individual whose insurance is providing the coverage**	
Insured's Street Address:	
Insured's City:	
Insured's State:	
Insured's Zip Code:	
Insured's Phone #:	
Insured's Date of Birth (mm/dd/yyyy):	
Insured's Gender:	Female Male
Insured's Employer: ***Please Note: Your mental health benefits may be administered by a different company than your card reflects***	
Phone # for Mental Health Benefits	
Insurance Company Claims Address:	
Deductible Amount: $ ****Please Note: Medical and mental health deductibles may differ and or be calculated separate****	
Deductible Amount Met: $ (If not, the deductible will be charged until met)	
Required to pay at:	
Copay Amount: $	
What is your visit limit?	
Is this an EAP referral/visit?	No Yes
Pre-Auth/Cert Needed for Visits?	No Yes #_____

Your information, including your status as our client is kept strictly confidential. We respect your legal right to confidentiality and will protect your information with the proper care. Identifying information will not be released without your permission. All records will be maintained in a confidential manner. Consent forms will be required for the release of any information. State, including the Kentucky Revised Statutes (KRS), and Federal laws may require the release of information without written or verbal consent in the following specific situations:

1. Medical or Mental Health Emergencies
2. Clients become a danger to themselves (Suicidal thoughts/behaviors/attempts, severe depression, etc.) **KRS 202A**
3. Clients become a danger to others (Homicidal thoughts/behaviors/attempts)
** The person threatened and the police will be notified. **KRS 400** **
4. Any report or suspected child abuse or neglect (Physical or sexual). **KRS 620**
5. A court order directing the release of information.
6. Any litigation initiated by the client related to treatment.
7. Any abuse of the elderly, with mental illness or who cannot care for themselves properly.

I consent to release any personal or clinical information required to process my claim to my insurance or my EAP provider. I also authorize any payments made by my insurance company or EAP provider to be paid directly to The Counseling Services of Michael C. Adams and Associates, PSC. This form will be considered a signature on file for all future insurance claims.

I understand and agree to the limits of confidentiality as indicated above. I agree to hold The Counseling Services of Michael C. Adams and Associates, PSC (MCA&A), harmless for any loss, cost and or damages sustained by my spouse, child or me. By signing this form, I hereby authorize MCA&A, any contracted clinician, associates or support staff of MCA&A to assess, diagnose and treat mental health and or substance abuse problems for myself, my family and or my child.

I acknowledge that I have received, read and understand above and the privacy practices of The Counseling Services of Michael C. Adams and Associates, PSC contained at the end of this packet.

_____

Client Name-Printed SS# of client DOB

_____

Client Signature **Parent Signature for minors under 18**

The Counseling Services of Michael C. Adams & Associates, PSC
7000 Houston Rd. Bldg. 200, Ste. #18 Florence, KY 41042
Phone: (859) 525-0185 | Fax: (859) 525-8100
admin@northernkentuckycounseling.com
www.northernkentuckycounseling.com

Service Type	**Charge** (effective and revised (4/13/18)
Initial Diagnostic Interview and/or Assessment	$130.00
53-60 Minute Individual Session	$125.00
53-60 Minute Family or Couples Session	$125.00
53-60 Minute Couples Therapy Session	$125.00
Gottman Method Couples Assessment	$200.00 Testing Fee and Scoring
Substance Abuse/Mental Health Assessment	$100.00 Testing Fee and Scoring
Adolescent/School Assessment	$100.00 Testing Fee and Scoring
Deposition	$500 plus $200 per hour
Court Appearance	$500 plus $200 per hour
Fail To Keep/Less than 24 Hour Cancellation ***Please Note: Your appointment time is reserved soley for you. We are very strict with this policy.***	$85.00 Minimum
Any matter in which we must hire an attorney to assist or protect our office involving your case, the case of a minor or a related case and any action brought upon our office by any attorney for any reason related to your case.	***All attorneys' fees billed to us by our attorney, plus any regular fees that we charge.***
Miscellaneous Fees	
Returned Check Fee	$50.00 minimum
Completed Forms (need 48 hour advance notice)	$25.00 for every ¼ hour minimum
Phone Calls and any other work outside session	$25.00 for every ¼ hour minimum
Medical Records	$1 per page after free copy
Prior Authorization (some insurances require pre-authorization, this is your responsibility, any delays in claim processing due to lack of authorization will result in this fee)	$15.00
Late Payments (60 days past service date)	$15.00 minimum or 10% of entire balance

PLEASE NOTE: Any and all work our office does on your part will be discussed prior to performing the service. By signing this form. I agree that all fees not paid by my insurance company will be my responsibility. **PAYMENT IS DUE AT TIME OF SERVICE INCLUDING DEDUCTIBLES, COPAYMENTS AND COINSURANCE**. It is our practice to collect the full amount of monies up front, for services provided, until your insurance company makes payments for claims. All credits will be refunded. I also agree to allow any fees not paid by myself, to be billed to my credit card on file. By signing this form I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions are based on sole discretion of president of MCA&A and documented by the clinician.

Client Signature _____ Date_____

Guardian Signature_____ Date _____ (if client is minor)

NO SERVICES WILL BE RENDERED WITHOUT THIS PAGE COMPLETED IN FULL

Failure to Keep Appointment and Late Cancellation Agreement

Please understand that your specific appointment time is made exclusively for you. We regularly have clients on a waiting/cancellation list. We ask that if you need to cancel or reschedule your appointment you contact us as soon as you can. We require at least 24 hours notice to cancel an appointment. **If you Fail to Cancel within 24 business hours or Fail to Keep your appointment, there will be a $85.00 fee. Weekend cancellations are not accepted.** Payment for this is expected prior to your next appointment.

- Please note: after any instance of 2 consecutive Late Cancellations or Fail to Keep Appointment times, no further appointments will be made until the fees are paid and your credit card on file may be charged. Excessive missed appts for any reason may result in removal from schedule.
- By signing below, you are attesting you understand and agree to the attendance agreement.

_____

Printed Name Signature Date

Credit Card Authorization Form

This form is not intended for primary method of payment. **Our office prefers cash or check. PAYMENT IS DUE AT TIME OF SERVICE.** We keep a copy in your confidential record for the reasons below:

1. To bill any **unpaid charges** that may accrue as a result of having a deductible, co-payment, or co-insurance and or any other fees agreed upon that were not paid at the time of service delivery. Also to collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program or managed care company. **(SEE FEE SCHEDULE)**
2. To bill any **Fail to Keep Appointment Fees or Late Cancellation Fees that are not paid by you. (SEE ABOVE)**
3. Any **Non Sufficient Funds** ("NSF") or **Returned Unpaid Check** amount plus returned check fees from your bank.

Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card. **Your signature also allows us to store your credit card information either entered here or swiped at the office encrypted electronically for future convenience and use.** To protect your information, we do not keep CVV codes stored in our system. If you decide to pay with cash/check, you agree to allow us to authorize your credit card $1.00 (which will be automatically refunded at that time) in order to store this card electronically. You also agree that any other credit card used in the future for payment will take the place of the one below.

NAME AS IT APPEARS EXACTLY ON CARD	TYPE OF CARD (CIRCLE ONE)	Type of Card (circle): Credit/Debit/HSA	Expiration		CVV/Security Code
		CARD #	M	Y	
	VISA MC AMEX DISC				

Signature:	Address (If different than home):
Date:	

Please Note: Our professional relationship is very important to us. It is our agency's desire to settle all accounts in an amicable matter.

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How did you hear about us? Insurance Company Psychology Today Search Engine EAP
Friend/Relative Website Other Provider Other-please list _____

Presenting Problem
Please describe in as much detail the symptoms of the problem and why you are seeking counseling?

When did these symptoms/problems start occurring? _____
What do you believe may be contributing to the problem? You may list specific behaviors, thoughts, feelings, attitudes, etc

What has worked in the past to assist with this problem? What have you tried that has not worked?

BioPsychoSocial History:
Please rate the following from 1-5
1=poor 2=below average 3 =average 4 =above average 5=excellent. Please give details of any rating below 3 in last box:

Diet	1 2 3 4 5	
Exercise	1 2 3 4 5	
Sleep	1 2 3 4 5	
Social Support	1 2 3 4 5	
Spiritual Involvement	1 2 3 4 5	

Please list any past or present medical issues you feel we should know about. (traumas, surgeries, disease etc.)

Please list any medications you are currently taking and what for:

Medication	Dose	Date Started	Purpose

Please list all previous Mental Health or Substance Abuse treatment you have received in the past:

Provider/Treatment Center Issue/Problem Dates of Service Outcome

Suicide/Homicidal Ideation Assessment:

In the **past** have you ever thought about harming yourself in anyway? Yes No

If yes, please list how long ago, and circumstances:

Do you have any thoughts or intentions of harming yourself now or in the near future? Yes No

Do you have any thoughts or intentions of harming some else right now? Yes No

If yes to either of the above, please list details including circumstances:

Drug/Alcohol Assessment

Please list all past/present use of alcohol, cigarettes or illicit drugs:

Type	Amount	Frequency	Date 1st Use	Date Last Use

Do you have any immediate or extended family members with a history of Mental Illness or Substance Abuse issues? If so, please list relation, the exact issues and if treated, how so?

What goals do you have for therapy?

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Privacy Practices of The Counseling Services of Michael C. Adams & Associates, PSC.
7000 Houston Rd. Bdng. 200, Suite #18, Florence, KY 41042
(859) 457-6853

Effective January 17th, 2012

This notice describes how health related information about you may be used and disclosed and how you can access this information. This notice applies to all of the records of your care generated by our office whether created by our office or an associated facility. This notice describes our practices policies which extend to: All employees, staff and other personnel that work for or with our practice (billing clerk, therapists, etc.). All office areas (front desk, waiting area, etc.); Our business associates (billing service, clearinghouse, covering therapists, etc.)

We are required by law to:

Make sure that medical information that identifies you is kept private, except in certain situations where we are allowed to disclose information under the protection or direction of state or federal law. Give you this notice of our legal duties and privacy practices with respect to medical information about you. Follow the terms of this notice now in effect.

Responsibilities:

Maintain the privacy of your health information as required by law, provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you, abide by the terms of this notice and notify you if we cannot accommodate a requested restriction or request. Accommodate your reasonable requests regarding methods to communicate health information with you. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our office containing the effective date. In addition, each time you visit our office for treatment, you may obtain a copy of the current notice in effect upon request. We will not use or disclose your heath information without your authorization except as described in this notice or in situations that can be reasonably inferred from the intended uses listed in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Patient Health Information Rights:

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:
Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted; Request that you be allowed to inspect and copy your health record and billing record– you may exercise this right by delivering the request in writing to our office; File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information; Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care; Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
Revoke authorizations that you made previously to use or disclose information except to the extent of information or action has already been taken by a written revocation to our office.

With your consent, the practice is permitted by federal privacy laws to make use and disclosure of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, assessment and test results, diagnoses, treatment and future care or treatment. You have a right to review this notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment and health care operations purposes.

How we use and disclose health information:

1. For Treatment: We may use your health related information to you to provide initial, ongoing, or referral services for you. This may mean discussing your case or collecting records from a previous provider or disclosing your records to collaborate with a previous, current or future provider, such as psychiatrists, psychiatric hospitals and or doctors or other healthcare professionals. The president of the practice, management, and or clinical supervisors may collaborate with your clinician(s) and review your information for supervision purposes. They may be included if there are emergency, safety, financial or ethical issues that should arise. If you are a minor certain healthcare information may be disclosed to your parents or guardian during treatment.
2. For Payment: We may use and disclose health related information in billing and insurance operations needed to collect payment for the services you have received. This information may be shared with your insurance, EAP, and or managed care company and will be viewed by our billing department. You may receive a bill at your address for services rendered. Your healthcare plan may require ongoing and updated detailed information of your treatment in order to provide payment as permitted by KY and USA laws. Individuals involved in your care or in payment of your care may also be informed of your healthcare. We will attempt to collect payment from you in reasonable ways including emails, phone calls and mailing statements. If we cannot collect for services, we may bill your credit card or use an outside collection agency. To protect your information, we do not store CVV codes on our system. They are only used for initial authorization and then redacted from your paperwork. We only keep the last 4 digits, expiration date and your name once you stop receiving services from us and your account is paid in full and for reference only. Credit Card information is kept on Merchant Warehouse servers, access through therapyappointment.com by a token system which is a reference to those numbers.
3. For Healthcare Operations: We may use or disclose information about you for practice operations. These uses and disclosures are necessary to run the operations efficiently and increase the quality of care we provide. For example, we may use your healthcare information to review our treatment and service and to evaluate our performance of our staff in providing your care. We may also use this information to determine the need for new services and to train students, billing personnel and other employees of the practice. (ex: rescheduling when sick). We may remove data that identifies you personally before others view it or use it to study healthcare delivery without identifying patients.
4. For Appointment Reminders: We may send reminders in the mail, by text, or leave phone messages both or which could be intercepted by others. If you do not wish for us to leave messages please indicate this with your therapist.
5. Emergency Situations: We may disclose medical information about you to an organization assisting with an emergency medical or mental health condition or crisis so that you may receive the proper health care and or so that your family can be notified about your condition.
6. Law Enforcement: We may release healthcare information if asked to do so by a law enforcement official in response to a court order, to protect and individual or yourself from imminent harm or danger, in emergency situations to report a crime or in the process of facilitating a transfer to a hospital of any kind.
7. Department of Community Based Services: We may disclose healthcare as required by KY law in order to report suspected child abuse or domestic violence of any kind.
8. Judicial/Administrative Proceedings, Probations Officers, Court designated Workers, Parole offices and Judges: Healthcare information may be disclosed to these individuals with a written consent to do so. We disclose detailed information including date and time of appointments, clinical progress and treatment compliance as well as other information requested and listed on the consent.

To Report a Problem please notify Michael Adams @ (859)-525-0185 or email him @ adams.michaelc@gmail.com
If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave, SW, Washington, D.C. 20201 or email to www.hhs.gov. There will be no retaliation for filing a complaint. The address for OCR is listed as follows

Office for Civil Rights:
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F, HHH Building
Washington, D.C. 20201
We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment.

Directions may also be obtained from our website: www.northernkentuckycounseling.com

Directions to our offices located in Florence: We have two locations at 7000 Houston Rd. Suite 11 and 18.
Our address is: 7000 Houston Rd. Bldg, 200, Suites #11 and #18, Florence, KY 41042 and are conveniently located in the Office Condominiums Across from Wal-Mart and next to Panera Bread. Please see the welcome letter to see which therapists work at which suites.
Please be advised we will most likely be in session and may not be able to answer if you are lost.

From Route 18 coming from Burlington: Turn Left onto Houston Rd, after first light turn right into office park. We are the second building from the left Suite #18.

From I-75 going North: Take KY-18, Exit 181 towards Florence/Burlington, take left onto KY-18. Turn right onto Houston Rd, after first light turn right into office park.

From I-75 going South: Take Exit 182 toward Turfway Rd, turn left at light onto Houston Rd. Go about 1 mile, turn left into second office park with the green roofs on left.

From Houston Rd coming from Turfway Rd or Route 236: Take Houston Rd toward KY-18. Office condominiums are across from Wal-Mart BEFORE you get to Panera. Turn left into second office park with the green roofs on left.

Please Note: We have two locations now within the same office park at 7000 Houston Rd. Please make sure you are going the right office by seeing which office your therapist is located at:

Suite 11
Kathryn Plymale
Brittany Bundy
Heather Spera
Alissa Lehn

Suite 18
Michael Adams
Bryan Purcell
Bettie Howe
Lindsey Moore
Kristen Gillespie
Rose Grimes
Erik Plymale

Please have a seat in the waiting area when you enter the office. Please enjoy any coffee or refreshments we have. We will come get you at your meeting time. We will likely be with a client until our meeting. We look very much look forward to meeting you!