Parent's Application and Appraisal Form

Date_____

Patient's Name_____DOB_____

Parent (s) Name_____Phone_____

Address_____Zip_____

Physician_____Phone_____

Adopted Child _____Yes _____No At what age_____

Mother's Name_____Father's Name_____

_____Natural _____Step
_____Adoptive _____Foster
Age_____Education (Years)_____

_____Natural _____Step
_____Adoptive _____Foster
Age_____Education (Years)_____

Marital status of of natural parents of child (check all that apply)

_____Married _____Living Together _____Mother Remarried
_____Not Married _____Separated _____Father Remarried
_____One Parent Deceased _____Divorced
Dates of Marriages From _____ to _____Number of years_____
Dates of Other Marriages From_____to _____Number of years_____

Children: Please list all living and deceased (including patient) in order:

Name	Age	Birth date	Sex	School	Grade

Any other persons living in the home: ___yes _____no Who?
Name_____Age_____Relationship_____

Was Alcohol, Drugs or Tobacco used during pregnancy?_____Yes_____No
If so, please explain_____

Who is/was closely involved in childcare besides mother/father up to age 5?

_____

Are there current concerns with any of the following?

_____Eating Problems	_____Bed Wetting	_____Masturbation
_____Sleep Difficulties	_____Wetting Pants	_____Runaway
_____Speech Difficulties	_____Soiling Pants	_____Temper Tantrums
_____High Fevers	_____Constipation	_____Fire Setting
_____Head Injuries	_____Headaches	_____Coordination
_____Hospitalizations	_____Avoids Being Held	_____Other Concerns

Explain_____

Is the child receiving medication? ____Yes ____No What?_____
Are other professional agencies involved? (SRS, Mental Health etc.)_____

_____

What is your child's difficulty and for how long?_____

_____

_____

_____

Has the teacher/school indicated concern? If so,
what?_____

_____

Family history of:

_____Alcoholism	_____Developmental Delays	_____Drug Abuse
_____Marital Problems	_____Learning Problems	_____Emotional Problems
_____Suicide	_____Other _____	

What do you hope to gain from this referral to Heartland Rural Counseling Services, Inc.?_____

_____

_____

Does the child have the following problems?

_____Hurt Self or Others	_____Low Self Esteem
_____Shy	_____Quiet and Withdrawn
_____Dislikes School	_____Hurts or Kills Pets/Animals

Indicate which characteristics your child has:

____Selfish	____Sex Difficulties	____Untruthful	____Inadequate
____Impulsive	____Quick Tempered	____Unruly	____Sensitive
____Resentful	____Scatterbrained	____Cruel	____Affectionate
____Secretive	____Resents Authority	____Awkward	____Vain
____Quarrelsome	____Inconsiderate	____Won't Mind	____Obedient
____Doesn't Care	____Silly	____Emotional	____Stubborn
____Sassy	____Untidy	____Clean	____Moody
____Leader	____Follower	____Other_____	

Mother: Check the statements, which best describe your parenting style.

_____ Too Strict	_____ Too Demanding	_____ Too Kind
_____ Too Busy	_____ Too Easy Going	_____ Too Short Tempered
_____ Too Lenient	_____ Too Severe	_____ Other _____

Father: Check the statements, which best describe your parenting style.

_____ Too Strict	_____ Too Demanding	_____ Too Kind
_____ Too Busy	_____ Too Easy Going	_____ Too Short Tempered
_____ Too Lenient	_____ Too Severe	_____ Other _____

Briefly comment on your child's friends _____

_____

_____

Please add any other comments or concerns that may help us to understand your child.

_____

_____

_____

Primary Insurance Name _____ **Group Number**_____
Person with Insurance_____
Address_____
Date of Birth of Insurance Card Holder_____
Employer _____
Card Holder Social Security Number _____

Secondary Insurance Name _____ **Group Number**_____
Parent Name with Insurance_____
Parent Address_____
Date of Birth of Insurance Card Holder_____
Parent Employer _____
Parent Social Security Number _____

I have been informed of the fee schedule for the counseling sessions I will be attending and understand I am responsible for payment on my account and will ensure payment is made.

_____ _____

Signature of Parent or Guardian Date

YOUTH SYMPTOMS CHECKLIST

Complete the following to assist in identifying symptoms of the child / adolescent.

I. Does this child exhibit any of these problems?

1.	Problems with sleeping	_____Yes	_____No
2.	Appetite change or weight change	_____Yes	_____No
3.	Irritability or temper outbursts	_____Yes	_____No
4.	Depressive statements (i.e. I wish I were dead.)	_____Yes	_____No
5.	Not coping in school as before	_____Yes	_____No
6.	Withdrawn or prefers being alone	_____Yes	_____No
7.	Frequent complaints of aches or pain	_____Yes	_____No
8.	Recent drop in school grades	_____Yes	_____No
9.	Has trouble making friends	_____Yes	_____No
10.	Usually chooses "problem kids" as friends	_____Yes	_____No
11.	Please describe any items answered "Yes":_____		

_____

_____

_____

_____

II. Does this child / adolescent exhibit any of these issues?

1.	Phobias or irrational fears	_____Yes	_____No
2.	Difficulties separating from parents	_____Yes	_____No
3.	Bouts of severe anxiety or panic	_____Yes	_____No
4.	Nightmares	_____Yes	_____No
5.	Repetitive behaviors (i.e. washing hands, checking locks, etc.)	_____Yes	_____No
6.	Pulling out hair or eyelashes	_____Yes	_____No

7. Please describe any items answered "Yes":_____

_____

_____

_____

_____

III. Does this child / adolescent exhibit any of these issues?

1.	Episodes of unusually high energy or talkativeness	_____Yes	_____No
2.	Attention problem / short attention span	_____Yes	_____No
3.	Does things impulsively	_____Yes	_____No
4.	Easily distracted from what he / she is doing	_____Yes	_____No
5.	Hyperactive according to teacher	_____Yes	_____No
6.	Abnormal movements (i.e. jerking or eye blinking, etc.)	_____Yes	_____No
7.	Excessive noises (i.e. throat clearing, sniffing, etc.)	_____Yes	_____No
8.	Please describe any items answered "Yes":_____		

_____

_____

_____

_____

IV. Does this child / adolescent exhibit any of these issues?

1.	Learning disabilities diagnosed	_____Yes	_____No

2. Learning or reading problems _____Yes _____No
3. Speech problems _____Yes _____No
4. Slow to learn _____Yes _____No
5. Ever suspected of being mentally handicapped _____Yes _____No
6. Ever said to be autistic _____Yes _____No
7. Please describe any items answered "Yes":_____

_____

_____

_____

_____

V. Does this child / adolescent exhibit any of these issues?

1. Attention / seeking behavior _____Yes _____No
2. Class clown _____Yes _____No
3. Uses obscene language _____Yes _____No
4. Often disrespectful of adults _____Yes _____No
5. Bossy _____Yes _____No
6. Refuses to do what he/she is told _____Yes _____No
7. Temper outbursts or aggressive outbursts _____Yes _____No
8. Problems with the law _____Yes _____No
9. Expelled or suspended from school _____Yes _____No
10. Runs away from home _____Yes _____No
11. Sets fires _____Yes _____No
12. Hurts animals or others _____Yes _____No
13. Steals _____Yes _____No
14. Frequently lies _____Yes _____No
15. Smokes _____Yes _____No
16. Drinks _____Yes _____No
17. Uses drugs _____Yes _____No
18. Frequently takes unnecessary risks for thrills _____Yes _____No
19. Frequently involved in fihts _____Yes _____No
20. Please describe any items answered "Yes":_____

_____

_____

_____

_____

VI. Does this child / adolescent exhibit any of these issues?

1. Ever sexually abused _____Yes _____No
2. Ever physically abused _____Yes _____No
3. Any inappropriate sexual behavior _____Yes _____No
4. Please describe any items answered "Yes":_____

_____

_____

_____

_____

VII. Does this child / adolescent exhibit any of these issues?

1. Temper tantrums _____Yes _____No
2. Plays with toys or objects in an unusual way _____Yes _____No
3. Head bangs, flaps, twirls, or rocks _____Yes _____No

4. Injures himself / herself (i.e. hitting, biting, etc.) _____Yes _____No
5. Picks at sores _____Yes _____No
6. Resistant to change _____Yes _____No
7. Please describe any items answered "Yes":_____

_____

_____

_____

_____

VIII. Does this child / adolescent exhibit any of these issues?

1. Talk to himself / herself _____Yes _____No
2. Have an imaginary friend _____Yes _____No
3. Ever appear to be hearing voices or seeing things _____Yes _____No
4. Appear paranoid or afraid of others _____Yes _____No
5. Have any odd or "off-the-wall" ideas _____Yes _____No
6. Please describe any items answered "Yes":_____

_____

_____

_____

_____

Client Name:_____ DOB:_____

Date Complete:_____ Gender:_____

Person Completing Checklist:_____ Relationship:_____

Heartland
Rural Counseling Services, Inc.

Provider Disclosure

My signature on the form indicates that the following information has been disclosed to me:

Name of Provider: Amanda J Lanning

Level of Education/Training: Licensed Specialist Clinical Social Work, Master Social Work,

EMDR Certified, Theraplay Trained, Autism Behavioral Specialist

Title(s) of the Provider: Licensed Specialist Clinical Social Work

Heartland Rural Counseling Executive Director: Amanda Lanning, LSCSW

License(s) number of the Provider: LSCSW #4969

Code of Ethics followed by Provider: National Association of Social Work

Please be advised that certain mental disorders can have medical or biological origins, and that you should consult with a physician.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

Heartland
Rural Counseling Services, Inc.

Billing Fees for Additional Services

Correspondence and Consultations:	
Telephone calls with client (5 minutes or more will be charged minimum of 15 min)	$120.00/hr.
Telephone calls with parent/guardian of client (5 minutes or more will be charged minimum of 15 min)	$120.00/hr.
Case Summary (report regarding client's progress for courts, schools, work, etc.)	$120.00/summary
Letters to insurance agencies (other than normal claim processing)	$120.00/summary
Consultation with therapist from outside agency regarding the client's case (5 minutes or more will be charged minimum of 15 min)	$120.00/hr.
Consultation with attorney or other professional regarding the client's case (5 minutes or more will be charged minimum of 15 min)	$120.00/hr.
Consultation with school for school staffing (IEP mtg, etc.) regarding the client's case (5 minutes or more will be charged minimum of 15 min)	$120.00/hr.
Court:	
Case Summary (report regarding client's progress for the courts)	$120.00/summary
Subpoena to appear in court and/or testify (minimum of one hour)	$120.00/hr.
Cancelled court appearance, less than 24 hours-notice (minimum of one hour)	$120.00/hr.
Travel time to the subpoena (outside of Colby)	$ 35.00/hr.
Mileage (will be charged in addition to travel time)	$0.55/mile
Phone testimony for court (minimum of one hour)	$150.00/hr.
Expert Witness Testimony (minimum of one hour)	$300.00/hr.
Court Appointed Anger Management Therapy:	
Course Fee	$880.00
Police Officer for issues of safety and security for therapist/client	$ 35.00/hr.
Supervised Visitation:	
Supervised Visitation	$150.00/hr.

** Prices subject to change

Please sign and date below indicating you have been provided accurate information and understand the limits of these charges and billing information.

_____ _____

Client Signature Date

Heartland
Rural Counseling Services, Inc.

Fee Agreement

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of the financial policy. **PLEASE ask any questions you may have BEFORE signing this agreement.** (please **initial** each statement after reading):

_____**Full payment is expected *at the time of service***. We accept payment in the form of cash or check.

- If you are unable to do so, it will be your responsibility to arrange for alternate payment plans which will be honored on an individual bases as needed. *Returned checks are subject to a fee of $35.00. Heartland Rural Counseling Services, Inc. reserves the right to charge interest on accounts over 90 days past due, and to send uncollected balances to collection agencies as needed.*

_____ My standard fee is $30 per 15 minutes with appointments being either 30 min., 45 min., 60 min. or 90 min. is length (Length of sessions will be determined by the client and therapist given their specific needs).

_____ Sliding fee scale rates are used with all clients to help enable them to receive services. The sliding fee scale is based on household income and family size. Heartland Rural Counseling Services, Inc. will verify your household income in order to determine the appropriate fee and payment plan. Eligibility for the sliding fee scale will be reevaluated every 6 months. ***Psychological testing services are not eligible for the sliding fee discount.***

- If you choose not to utilize a sliding fee scale, a standard fee of $120 per hour will apply.

_____ A session consists of the length of session time agreed to by the therapist and client minus 10 min. The additional 10 minutes covers time spent documenting our time together. Should our appointment run over in time, you will be billed to the next 15-minute increment of time.

_____ Assessment charges [such as specified Psychological Evaluation(s), and Specific Psychological Measurement Scales] are subject to additional fees not included in your regular hourly rate.

_____ Services that will be charged in addition to your regular service are based on a minimum of 15-minute increments (For additional fee subjectivity please see Heartland Rural Counseling Services *Billing Fees* paperwork)

_____ Crisis management services are ***not eligible for a sliding fee scale discount*** and will be charged a minimum of $150 per hour. This includes, but is not limited to, crisis services during regular working hours, phone calls and/or answering text messages after regular working hours, evening and/or weekend consultations and appointments requiring your therapist's services.

My signature below indicates that I have read and understand these office and financial policies and that I agree to these terms.

_____ _____

Client/Responsible Party Signature Date

_____ _____

Client Signature Date

Heartland
Rural Counseling Services, Inc.

Sliding Fee Scale Application

Discounts are offered based upon family/household size and annual income. A sliding fee schedule is used to calculate the basic discount and is updated each year using the Federal Poverty Guidelines. Once approved, the discount will be honored for six months, after which the client must reapply. Acceptance of sliding scale fee is based on availability.

Please complete the following and return it to this office to determine if you or members of your family are eligible for a discount. A completed application requires documentation of household income (copy of tax return, etc.).

Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

HOUSEHOLD INCOME (Complete **one** column for each person)				
	Annual	Monthly	Bi-Weekly	Weekly
Self				
Spouse				
Total				

Dependent children under 18	
Other related adults residing in home	

Total Number Supported by Income	

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Printed Name _____ Signature _____ Date _____

FOR OFFICE USE ONLY:

Client Name _____ Date Approved _____

Discount: Full Scale Rate $120.00 - _____% = 45min _____ 60 min. _____ 90 min. _____

Discount valid through _____ (6 months from date of approval)

Heartland
Rural Counseling Services, Inc.

Consent to Communicate Via Electronic Media

Please initial each statement regarding technologic communication:

_____ I agree to allow Heartland Rural Counseling Services to contact me via **cell phone** via phone call or text message to arrange appointments or to discuss my status.

_____ I agree to allow Heartland Rural Counseling Services to contact me via **Email** to arrange appointments or to discuss my status.

_____ I understand that communication via texting or email will likely not be responded to immediately. It is understood that a response will be given within 24-72 hours of my message and that if it is an emergency, I will dial 911 for immediate help.

_____ I understand that I am welcome to send anything I desire to my therapist, but that therapy will not take place via text message or email and that all therapy related communication will be addressed in person at the following scheduled appointment.

I understand that even though Heartland Rural Counseling Services, Inc. has security measures in place to protect my HIPAA information, communication via electronic media, including cell phones and internet, is not secure and may cause an unintentional breach in my privacy. Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

Refusal

☐ I do **NOT** want Heartland Rural Counseling Services to contact me via ***cell phone***

☐ I do **NOT** want Heartland Rural Counseling Services to contact me via ***Email***

Heartland
Rural Counseling Services, Inc.

Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer-generated voice message) the day before your scheduled appointments.

Your name: _____

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone

_____ Via an email message

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Therapy Appointment Login Information:

(if you registered yourself on Therapy Appointment, please provide your login information; this will be held on file so if you forget I have it available for you)

Login Name: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

(Letters or numbers only)

Password: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

(Letters or numbers only)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

_____ _____

Client/Representative Signature Date

_____ _____

Provider Signature Date

Heartland
Rural Counseling Services, Inc.

Broken Appointment Policy

Heartland Rural Counseling Services, Inc. values your business. Your appointment is a time that has been set aside exclusively for you and your provider. We understand that your time is valuable to you, and in an effort to respect your time and that of our other parties, we ask that you respect our business scheduling policies. Please notify us at least 24 hours in advance of any cancellation.

Heartland Rural Counseling Services adheres to a four missed appointment guideline. This policy states that after a client has either ***rescheduled with less than a 24-hour notice, has not shown up for their scheduled time slot, or a combination, four different times your provider will not reschedule for another appointment.*** The therapist you are working with will give you appropriate referrals to another mental health provider in the area.

By signing this, I agree to Heartland Rural Counseling Services' broken appointment policy.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

Heartland
Rural Counseling Services, Inc.

Consent to Treatment

By signing below, I indicate that:

- I have been informed that my therapist, Amanda J. Lanning, is a Licensed Specialist Clinical Social Worker (LSCSW #4969).
- I understand my therapist is ethically and legally required to discuss clinical work with the above-named supervisors and these supervisors are bound to the same degree of confidentiality as the evaluator and this agency.
- I understand that the therapist is bound by the Code of Ethics set forth by the American Psychological Association (APA) and that I can request a copy of those ethics at any time.
- I understand that, except under specific circumstances mandated by law, communication with my therapist will remain confidential as will any records regarding the therapy process unless I, and all other adults involved in therapy with me, give written permission that such information may be released.
- I understand that, under Kansas law, specific circumstances require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) a therapist believes a client may be a danger to him or herself or to others; b) the therapist believes that a child, elderly, or disabled person may be subject to abuse or neglect; and c) when a court order exists that information regarding the therapy process be provided.
- I am aware that mental health issues are often related to medical or biological causes and I am willing to work with other medical professionals to address these possibilities. I realize that I can decide whether I would like my therapist to consult with this professional.
- I understand that, under Kansas Law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a release of information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time, if I so request.
- I understand that there can be risks and benefits associated with therapy and have discussed those with the therapist.
- I have reviewed the Notice of Privacy Practices regarding HIPAA protections and had questions answered about the use of my protected health information (PHI).

- I am aware that my insurance company or other third-party payers may be given information about the provider, my diagnoses and progress to illustrate a need for services, the type of service received, and the dates of services provided.

- I understand that, as a client, I have certain rights and responsibilities and those rights have been reviewed with me by my therapist.

- I agree to take an active role in developing appropriate goals, a treatment plan, and in regularly reviewing our work together so it better meets my needs.

- I can ask my therapist at any time about the type of therapy we are engaged in, the research that backs it up, and potential alternatives towards meeting my goals.

- I am aware I can stop treatment at any time and agree to discuss the termination of therapy at a regular therapy session. I understand that if I chose to terminate services, referrals to other mental health professionals will be provided upon request.

- I recognize that other roles I have with my therapist will be discussed and examined to determine how to minimize misunderstandings and to maintain confidentiality; potentially harmful dual roles will attempt to be avoided.

- I understand that if arrangements are not made and/or payment is not received, that the therapist may stop providing services.

- I understand that, if needed, a third-party collection agency may be utilized to obtain reimbursement- if this occurs, my identity as a client and contact information, as well as the dates of services will be provided, but the rest of my information should remain confidential.

- I understand that if I am involved in a court case, that I will ask my attorney not to involve my therapist in the case and will advise them not to subpoena him/her to court.

My signature below indicates that I give my full and informed consent to receive professional counseling from Amanda J. Lanning, LSCSW, Licensed Specialist Clinical Social Work.

_____ _____

Signature of Client/Representative Date

_____ _____

Printed Name of Client/Representative Relationship to Client

_____ _____

Signature of Provider Date

Heartland
Rural Counseling Services, Inc.

Client Rights, Risks and Benefits

Client Rights

All Clients have rights concerning their therapy

You have the right to:

- Ask questions about your therapy
- Be fully informed of the limits of confidentiality in the therapy setting
- Be fully informed about the fees for therapy and the method of payment
- Know the Code of Ethics followed by my therapist at Heartland Rural Counseling Service, Inc.
- Specify and negotiate therapeutic goals and to renegotiate them when necessary
- Decide not to receive therapeutic help from a therapist at Heartland Rural Counseling Services, Inc.
- End therapy at any time without any moral, legal, or financial obligations other than those already incurred

Risks and Benefits

When you seek therapy, it is important to know that there are benefits and risks involved in the changes that my occur.

The benefits of therapy can include an enhancement of your ability to handle or cope with your marriage, family, and other relationships in a healthier way. You may also gain a greater understanding of personal and family goals and values. This new understanding may lead the way to greater maturity and happiness as an individual, a couple, or a family.

However, therapy can be challenging and uncomfortable at times. Remembering and resolving unpleasant events may cause intense feelings of fear, anger, depression, and frustration. As you work to resolve issues between your family members, marriage partner, and others, you may experience discomfort and an increase in conflict. There may be changes in your relationship you had not originally intended.

Your therapist will discuss with you the benefits and risks involved in your particular situation. Please discuss with your therapist any concerns you have as your therapy progresses.

_____ _____

Client Signature Date

Heartland
Rural Counseling Services, Inc.

Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the full, legally required notice of privacy practice. You may request a copy of the full version at any time. Please talk to your therapist/evaluator about any questions or problems.

How we use and disclose your protected health information (PHI) with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations**. After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign the form, we cannot treat or evaluate you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. Where there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a court order requires us to do so
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment of your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See Below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our executive director, and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our Executive Director who can be reached by phone at: 785-460-7588 or by email at : mandy@st-tel.net.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

Heartland
Rural Counseling Services, Inc.

Consent to Use and Disclose Your Health Information

Heartland Rural Counseling, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form is an agreement between you, and me/us, When we use the words, "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you, By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you are concerned about your PHI, you have the right to ask us to not use or share some of it for treatment, payment, or administrative purposes. You will need to provide us with what your wishes are in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it, by writing to Mandy Lanning, Executive Director. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at: 785-460-7588.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The practice has the right to change the Notice of Privacy Policies
- The client has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this contract.

_____ _____

Client Signature (Or his/her representative) Date

_____ _____

Provider Signature Date

Heartland
Rural Counseling Services, Inc.

Waiver of Medical/Psychiatric Consultation

I understand that under the provisions of Kansas Statues, my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is being used that may be contributing to any signs of mental disorder that she/he may have observed while working with me or my minor child listed below:

_____

Name of Client or Name of Minor Child

In the event that I or my minor child does not have a primary care physician or psychiatrist, I acknowledge that my therapist has recommended that I seek medical consultation.

By signing below, I am indicating that I waive my right to such consultation and that I am aware that this waiver will become part of my client record.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

Heartland
Rural Counseling Services, Inc.

Consent to Treatment for Telehealth Services

Definition of Telehealth:

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

- The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards self or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be unintentionally lost or accessed by unauthorized persons. HRCS utilizes secure, encrypted audio/video transmission software to deliver telehealth.

- I understand that different states have different regulations for the use of telehealth. I understand that I and my therapist must be present within the state of Kansas during any and all telehealth services. I understand that telehealth services will not be provided if either I or the therapist are not within the state of Kansas during an agreed upon session time.

- I understand it is my responsibility to find a ***private stationary location*** where I can speak with my therapist during a session. I agree to treat a telehealth session the same as I would if I were in the therapist's office. I understand therapy is for me and I agree to prevent the presence of all other persons (friends, siblings, teachers, etc.) in the room while in session. If the client is a minor, the client will only allow their parent(s)/guardian(s) in the room with them during a telehealth session (if necessary) and prevent the presence of all other persons (friends, siblings, teachers, etc.) in the room while in session.

- I understand that if the above-mentioned privacy cannot be obtained during a scheduled telehealth session, the session will be rescheduled to another time when privacy can be obtained. I understand that if a scheduled telehealth session must, in the moment, be rescheduled due to privacy breaches on my (the client) end, I will still be responsible for the payment of said session time.

- I understand that if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services), I will be informed and if necessary, referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

- I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my therapist, I may be directed to "face-to-face" psychotherapy.

- I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. On occasion, others may also be present during the consultation other than my therapist in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

- I understand that my express consent is required to forward my personally identifiable information to a third party.

- I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

- By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

_____ _____

Signature of Client/Representative Date

_____ _____

Printed Name of Client/Representative Relationship to Client

_____ _____

Provider Signature Date