

## Client Information and Consent Form



Kanawha Pastoral Counseling Center  
16 Leon Sullivan Way, Suite 300 Charleston, WV 25301 304-346-9689

Name \_\_\_\_\_

Street \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address (useful for scheduling - please print clearly) \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS # \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex (M/F) \_\_\_\_

Emergency contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent, Guardian or Family Member: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Information: (Please give your insurance card to the receptionist so we can make a copy of it for our records.)

Name of Insurance Co: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Group / Policy #: \_\_\_\_\_

### Authorization and Consent for Treatment and HIPAA Notification

I hereby give my consent to KPCC to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I understand that KPCC is a pastoral counseling training center, and that my clinician may be a non-licensed intern or resident under supervision.

I authorize KPCC to directly bill and receive payment from my insurance company and/or other persons liable to pay my bill. I assign my right to receive payment directly from any available source to KPCC. I will get authorization from my insurance company for any of KPCC's services if it is required by my policy. I will personally pay all charges not paid by my insurance company or anyone else.

I have received a copy of the KPCC "Notice of Privacy Practices." I understand that KPCC may make verbal summaries or send summaries or records of my evaluation and/or treatment to my insurance/managed care company for clinical review as part of its responsibility to manage my care. I further understand that these services are confidential and that information about me will not be disclosed or released to anyone other than authorized KPCC staff without my written consent, with the following exceptions: 1. Information necessary to authorize services or pay claims will be communicated to the insurer/claims payor when required. 2. If I disclose information in the course of evaluation or treatment which indicates I present a clear and present danger to myself or others. 3. As mandated by state or federal law.

**Signature of Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by guardian, guardian's authority is based on \_\_\_\_\_

## Client / Therapist Agreement



Kanawha Pastoral Counseling Center  
16 Leon Sullivan Way, Suite 300  
Charleston, WV 25301  
304-346-9689 www.kpcc.com

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I agree to abide by the following policies in my relationship with my therapist and Kanawha Pastoral Counseling Center, Inc.

1. I agree to keep any appointment made between me and my therapist. I understand that any change or cancellation must be made 24 hours in advance of the appointment time or the Missed Session Fee will be charged. Messages can be left on KPCC voice mail when the office is closed. If my Insurance does not pay for a late cancellation, I will be responsible for the full fee. Sessions are considered canceled due to inclement weather if there is a county school closing. Missed group sessions will be charged full group fee, even with advanced notice.
2. I may be asked to have a psychiatric examination, a medical checkup, and/or psychological testing. I will be responsible for these fees. Appointments with the KPCC Medical Director require advanced payment of the full fee, payments are expected before the appointment is scheduled.
3. My confidentiality will be carefully protected by the KPCC staff. I am aware of specific situations in which WV law sets limits on my privilege of confidentiality: These are if I disclose to my therapist or a staff member any of the following: a) my intent to harm myself; b) my intent to harm other persons; c) my involvement in abuse or neglect of children or of elders. I will be honest and candid with my therapist about any of the above impulses or actions. I understand that KPCC will take action to protect me or others; such as notifying the Department of Human Services and/or other appropriate persons or agencies.
4. KPCC may offer me a fee subsidy based on my financial circumstances. This subsidy will not apply for missed sessions, for psychiatric services, or for case management services, such as letters or conferences related to my therapy or for offering legal testimony, etc.
5. Telephone contacts for purposes other than setting appointment time will be billed on a prorated basis. Long distance conferences will be initiated by the client.
6. KPCC office hours are Monday through Friday, 9 am through 5 pm. My therapist will be available to meet with me by appointment only. Emergency services are not available at KPCC. If I am in crisis I agree to seek help through the Emergency Room services of the hospital closest to me, or by calling 911. If I anticipate a crisis I will make arrangements with my therapist for appropriate support.
7. If I receive a benefit for therapy costs through a health insurance plan, I may elect to pay my share at the time of the session and to sign over insurance payments to the Center. Statements not honored by the insurance company remain my responsibility. I will reimburse KPCC for any insurance benefit incorrectly paid to me.
8. Fees: \$ 130 per 45 minute session; \$65 per group session; \$130 case management hour  
My payment: \$ \_\_\_\_\_; insurance payment: \$ \_\_\_\_\_; Other 3rd Party \$ \_\_\_\_\_;  
Fee Subsidy: \$ \_\_\_\_\_; deferral: \$ \_\_\_\_\_  
Missed Session / Late Cancellation Fee: \$ \_\_\_\_\_; (*minimum missed / late fee is \$30.00*)  
I understand that payment is expected and due at the time of each session.

9. I understand and agree to follow the KPCC policies stated above:


\_\_\_\_\_  
Witness

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Medical History Form**

 Kanawha Pastoral Counseling Center  
16 Leon Sullivan Way, Suite 300  
Charleston, WV 25301  
304-346-9689

Client Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Family History:**

Where were you born? \_\_\_\_\_ Where did you grow up? \_\_\_\_\_

Number of siblings \_\_\_\_\_ Your birth order \_\_\_\_\_ (youngest, oldest, etc.)

Do you have any family members who have been in counseling or hospitalized for psychiatric reasons?

Do you have any family members who have struggled with addictions?

Do you have any family members who have struggled with hurting themselves or others?

**Medical/Surgical History:**

Do you have a regular Doctor? \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last checkup \_\_\_\_\_

KPCC encourages its clients to have a regular medical exam at least once a year. Medical issues can sometimes cause mental, emotional or relational distress, and so it is important to rule these out as not being a factor in what has brought you to counseling.

If you do not have a regular doctor, we urge you to get one. If you do not have insurance or a medical card, you may qualify for free medical service at HealthRight. We have information on HealthRight in the main office, or from your therapist.

Please check any illness you currently have or had in the past.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease  | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> (Syphilis/ gonorrhea) |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Jaundice      | <input type="checkbox"/> Kidney Disorder       |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Head Injuries         |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> TB                  | <input type="checkbox"/> Cirrhosis     | <input type="checkbox"/> Injuries              |
| <input type="checkbox"/> Ulcer           | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Muscular Disorder     |
| <input type="checkbox"/> Nerve Disorder  | <input type="checkbox"/> Seizures            |  |  |

Other: \_\_\_\_\_

**(over please)**

Please list any medications you are currently taking

Medication	Dosage	Reason	Start Date	Doctor

Any drug sensitivities or allergies: \_\_\_\_\_

Daily consumption of coffee, tea, or soft drinks containing caffeine: \_\_\_\_\_

Estimated consumption of tobacco: \_\_\_\_\_ per day per week. Type: \_\_\_\_\_

Estimated consumption of alcohol: \_\_\_\_\_ per day per week. Type: \_\_\_\_\_

Estimated use of “recreational drugs”: \_\_\_\_\_ per day per week Type: \_\_\_\_\_

Do you have easy access to a firearm? \_\_\_\_\_ Is it loaded? \_\_\_\_\_ Is it locked? \_\_\_\_\_

KPCC recommends that client who have access to firearms take precautions that the firearm be locked and stored unloaded. If there is anyone in your household, including yourself, who may be depressed or angry, we urge you to remove the firearm completely form the house.

Traumatic Life Experiences \_\_\_\_\_

\_\_\_\_\_

Have you had counseling before? When? \_\_\_\_\_

With Whom? Was it helpful? \_\_\_\_\_


Have you ever thought about hurting yourself? \_\_\_\_\_ How recently? \_\_\_\_\_

Have you ever tried to hurt yourself? \_\_\_\_\_ How recently? \_\_\_\_\_

Have you ever thought about hurting someone else? \_\_\_\_\_ How recently? \_\_\_\_\_

Have you ever tried to hurt someone else? \_\_\_\_\_ How recently? \_\_\_\_\_

## Symptom Checklist

 Kanawha Pastoral Counseling Center  
 16 Leon Sullivan Way, Suite 300  
 Charleston, WV 25301  
 304-346-9689 www.kpcc.com

Name \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Listed below are a number of categories in which persons commonly find some difficulties. Please indicate how you are affected by each by circling the appropriate number. Circle a number for every item. Please use the number scale outlined below.

Not a Problem	A Slight Problem	Moderate Problem	Serious Problem	Severe Problem
1	2	3	4	5

	<b>Your Physical Functions</b>		
1	Sleep Pattern	1 2 3 4 5	29
2	Eating Pattern	1 2 3 4 5	30
3	Bladder Control	1 2 3 4 5	31
4	Bowel Control	1 2 3 4 5	32
5	Seizures or Convulsions	1 2 3 4 5	
6	Speech (stuttering or stammering)	1 2 3 4 5	
7	Weight Problem	1 2 3 4 5	
8	Sexual Functioning	1 2 3 4 5	
9	Other	1 2 3 4 5	
	<b>Your Experience at Work</b>		
10	General Performance	1 2 3 4 5	33
11	General Satisfaction	1 2 3 4 5	34
12	Lateness	1 2 3 4 5	35
13	Absenteeism	1 2 3 4 5	36
14	Negative Feelings about Work	1 2 3 4 5	37
15	Relating to Supervisors	1 2 3 4 5	38
16	Relating to Co-Workers	1 2 3 4 5	39
17	Relating to Supervisees	1 2 3 4 5	40
18	Other	1 2 3 4 5	41
	<b>Your Behavior</b>		
19	Difficulty with Daily Routine	1 2 3 4 5	42
20	Letting Others Take Advantage of You	1 2 3 4 5	43
21	Hyperactivity (Can't sit still)	1 2 3 4 5	44
22	Repeating Certain Acts, Again and Again	1 2 3 4 5	45
23	Physically Abusing Others	1 2 3 4 5	46
24	Using Alcohol to Cope with Problems	1 2 3 4 5	47
25	Using Drugs to Cope with Problems	1 2 3 4 5	48
26	Lying	1 2 3 4 5	49
27	Stealing	1 2 3 4 5	50
28	Withdrawal from Others Socially	1 2 3 4 5	51
			52

Please list any particular worries you have about the symptoms you have listed:

What do you think is causing your symptoms?

Have any of the symptoms affected your daily life and activities? How?

What are your goals for therapy here at KPCC?

Would you like prayer to be a part of your sessions? yes / no / maybe / sometimes

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*Client Signature*

*Date*

**Notice of Privacy Practices  
Kanawha Pastoral Counseling Center (KPCC)**

Effective Date: April 13, 2003

**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.**

The privacy of your health information is very important to us and we want to do everything possible to protect that privacy. We have an ethical and a legal responsibility under federal and state law to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. Please feel free to ask for clarification about anything in this material.

**Here are some examples of how we use and disclose information about your health information.**

We may use or disclose your health information...

1. To anyone on our staff involved in your treatment program. This includes paid and volunteer, clinical and administrative staff, on a need to know basis.
2. To set-up and receive payment from you or from a third party payer (such as your insurance) for services we provide for you.
3. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, and improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
4. We also may disclose your health information to your physician or other healthcare provider who is also treating you.
5. To professional business associates, such as a contracted medical billing agency. Business associates are expected and required to protect and safeguard our information with the highest professional standards.
6. To anyone you give us written authorization to have your protected health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect the disclosure of your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.
8. To avoid harm or if you are a danger to yourself or others. We may provide your health information to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. Disclosure is compelled or permitted if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent a threatened danger. Disclosure is mandated, if we have a reasonable suspicion of child abuse or neglect, or if we have a reasonable suspicion of elder abuse or dependent adult abuse or neglect. Disclosure is compelled or permitted by us if you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
7. To any person required by federal, state, or local laws to have lawful access to your treatment program. These may include, but are not limited to, circumstances involving clients who are military personnel, cases involving worker compensation, or if there is the possibility of a public health risk.

We also may contact you for the purpose of setting up appointment, appointment reminders, to provide you with treatment alternative and health-related information, and as part of our fund-raising efforts. We will not use your protected health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We may use non-identifiable information, such as demographic and statistic information, in these ways. We will not use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

**As a client of Kanawha Pastoral Counseling Center you have these important rights:**

- A. With limited exceptions, you can make a written request to inspect your protected health information that is maintained by us for our use. You can ask us for photocopies of this information. We will charge you \$0.25 per page for making these photocopies.
- B. You have a right to a copy of this notice at no charge.
- C. You can make a written request to have us communicate with you about your health information by alternative means, such as by fax only, or at an alternative location, such as to your work place only. Your written request must specify the alternative means and location.
- D. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
- E. You can make a written request that we amend any part of your health information. If we approve your written amendment, we will change or make addendums to our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing. If we deny your amendment we will do so in writing. You can place a written statement in our records disagreeing with our denial of your request.
- F. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than for treatment, payment, or operations. This can go back as far as six years, but not before April 13, 2003. If you request this accounting more than once in a twelve month period we may charge you a fee based on our costs of tabulating these disclosures.
- G. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Privacy Officer, Kanawha Pastoral Counseling Center, 16 Leon Sullivan Way, Suite 300, Charleston, WV 25301, 304-346-9689 You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

We encourage you to provide your therapist with any concerns or complaints you may have about our privacy practices. We will try to accommodate your concern as quickly as possible.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in our privacy practices will effect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at the Kanawha Pastoral Counseling Center. These changes could also effect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice if you are an active client at the time of the change. When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you. Our most current notice is also posted in our office and on-line at [www.kpcc.com](http://www.kpcc.com).