Candy Smith MS, LCPC
10616 W 132nd Place
Overland Park KS 66213
913 232-1960
www.candysmithcounseling.com

Today's Date:_____

Name:_____ Age:_____ Phone # _____

Name:_____ Age:_____ Phone # _____

Name:_____ Age:_____ Phone # _____

Name:_____ Age:_____ Phone # _____

Home Address:_____

City:_____State:_____Zip Code:_____

Email Address:_____ May we email this address? y/n

Email Address:_____ May we email this address? y/n

Employer Name:_____ Phone #:_____

Doctor's Name :_____ Phone #:_____

Emergency Contact:_____ Phone #_____

Relationship to client:_____

I authorize my therapist to contact my emergency contact if warranted:

Client signature:_____ Date: _____

Client signature:_____ Date: _____

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Client (s) _____

LIMITATIONS OF CONFIDENTIALITY

There are limits to client confidentiality. Certain circumstances require disclosure of confidential information by your therapist. Your therapist will be required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or someone else.
2. You seek treatment to avoid rightful detection or apprehension by legal authorities or to enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. You are under the age of 16 years and a victim of a crime.
5. You are a minor and your therapist reasonably suspects you are a victim of child abuse, including emotional, physical, or sexual abuse.
6. You are over 16 and you reveal yourself to be a perpetrator of child or elder abuse, includingemotional, physical, and sexual abuse.
7. You are 65 or older and your therapist believes you are the victim of elder abuse, includingemotional, physical, and sexual abuse.
8. You die and the communication is important to decide an issue concerning deed or conveyance,will or other writing executed by you.
9. You file suit against your therapist for breach of duty, or your therapist files suit against you for any reason.
11. You have filed suit against anyone and have claimed emotional or mental damages as part of the suit.
12. You waive your right to privilege or give consent to limited disclosure by your therapist.
13. Your insurance company is paying for your services and requests information from your file.

I have reviewed the above Limitations to Confidentiality. I agree to the terms listed in this document.

Signature (client or guardian of minor)_____Date_____

Signature (client or guardian of minor)_____Date_____

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POLICIES AND PROCEDURES FOR COUNSELING

1. I understand that my therapist will work with me to develop a treatment plan that will deal with my reasons for counseling as quickly and effectively as possible.

2. If I am late, that time is lost from my session. If I am more than 15 minutes late, I may not be seen, but I am still responsible for payment for the session.

3. I understand that since I have reserved time with my therapist that cannot be offered to anyone else, a missed appointment, not canceled 24 hours in advance, will be billed to and paid by me at the regular hourly rate. A phone call or text to my cell number, 913 232-1960, is the only form of communication that will be considered valid. Email will not be considered.

4. Fees for a 50-minute session are $200. Fees for an 80-minute session are $300. Fees for administrative services (such as writing reports or letters, preparing for legal presentation, etc.) are $150per hour initially and $50 for every15 minutes thereafter. Fees for phone conversations that extend beyond appointment scheduling, confirmation, and cancellations will be billed to you at $50 per 15-minute increment. Fees are the same for in person and virtual sessions.

5. I understand that I am responsible for all charges incurred by me as a result of seeking treatment from my therapist.

6. Fees for services are due at the beginning of every session. If I plan to submit my fees to an insurance company, I will ask my therapist to provide a receipt to me with the necessary procedure codes. I understand that I am responsible for collecting all reimbursements from my insurance company.

Initial _____

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7. I will provide a debit, HSA, Flex Spending, or credit card to be kept on file. My therapist will bill all balances due, late cancel fees, and no show fees to this debit or credit card. I understand that I am responsible for all of these fees and I authorize my therapist to charge these fees to my debit card or credit card.

Card #_____ Exp: _____/_____ CVV:_____

Name on Card_____ Billing Zip Code _____

8. I understand that a $30 service fee will be added to all checks returned by my bank. If my account is sent to collections, a 25% collection fee will be added to my balance.

9. I understand that Candy Smith is an online therapist during virtual sessions.

I have reviewed the above Policies and Procedures for Counseling. I agree to the terms listed in this document.

Signature (client or guardian of minor) _____Date _____

Signature (client or guardian of minor) _____Date _____

Optional Information

Please tell me anything you'd like me to know about yourself, your situation, your goals, etc., before we meet: