Welcome: Thank you for choosing me as your counselor. Please read all information below before signing. It's important that you understand the information contained in this document. If you have any questions at any time, please do not hesitate to ask. I want you to understand and feel comfortable with my policies.

Appointments: Please call 636-388-2129 or email klrddr2012@gmail.com for appointments. Email cannot be guaranteed to be 100% secure so I engage in brief email communications for scheduling only. I do not participate in electronic conversations or email therapy. To schedule/cancel/reschedule **call at least 24 hours in advance or you will be charged $50** for the missed appointment. Therapy sessions are 45-50 minutes.

Agreement for payment: In consideration of rendering therapeutic services at Anchor of Hope LLC the undersigned (whether signing as the patients, or as parent, legal guardian, spouse, or representative of the patient) do hereby agree and guarantee payment in full of any and all charges for service rendered to or for the patients of Anchor of Hope LLC.

Records: All patients' notes are held according to HIPAA guidelines. Anchor of Hope will NOT be used for divorce and or child custody issues, so **Please DO NOT subpoena me and the notes to court.** My FEE in this event is $250 per hour plus I need 21 day notice to prepare my present patients. Payment is due 48 hours in advance and is NON-Refundable.

Insurance Reimbursement: Please be aware that if you wish to have your insurance reimburse you for counseling services, they will require disclosure of personal information and a diagnosis. If you wish for your insurance company to be billed, your signature below will represent your agreement for release of your private information.

Emergencies: If you are having a medical/mental health emergency, please call 911 or go to your local emergency room. Life Crisis Services may be reached at 1-800-273-TALK if you are feeling suicidal or are in emotional distress. Crisis text line provides free crisis intervention via texting 741-741. When you are stabilized please call me, or ask someone to call on your behalf.

Consent to Treatment: There are no guarantees to the outcome of therapy. Benefits may include more satisfying relationships, improved mood, greater optimism, and changes in behavior. Risks may include discomfort during sessions as difficult/painful issues are discussed and processed. Negative effects are usually short term. Please share any concerns with me throughout our work together. I am entering into this therapy contract with full understanding, participation, and consent. I know I have a right to a second opinion from another mental health professional, if desired, and I have the right to terminate therapy at any time.

Anchor of Hope, LLC: Policies & Fees

Kelly L. Roberts, MED, LPC

37 St. Andrews Dr., Union, MO 63084

(Located in Complete Chiropractic office)

Client's name: ____Date of birth: _______________

Legal Guardian (for minor client) ____

Address: _______________________________ City/Zip: _______________________________

Cell Phone number:____________________________Email ______________________________

Can I send a reminder text or call for appointment? Yes No Marital Status M S W D

Primary Language:_____________________________ Sex: M F

Employer/School: ____________________________________Occupation__________________

Name of insured: ____________________________ Insured's date of birth: ________________

Primary Insurance Company, ID #, and copay____

EAP company name and authorization # ____

Secondary Insurance Company and ID#____

Name and phone number of primary Doctor: ____

Current Medications and Dosages:____

____

Medical and/or Psychiatric Diagnosis:____

What brings you here today: ____

____

In the event that the therapist believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person(s) in danger and to **contact the following persons**, in addition to medical and law enforcement personnel:

Names ____Phone(____)_____________________

I have filled out and read both pages and understand the risk and hereby give my consent (consent to minor) for treatment and services provided by Anchor of Hope LLC. I also received a Notice of Privacy Practices and agree to the terms as stated.

Date____________________ Signed____

NOTICE OF PRIVACY PRACTICES

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.

I will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"). I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoked in writing as provided in the Privacy Regulations. I am permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment, and health care operations. For example, protected health information may be disclosed from one staff member to another for consultation.

Subject to requirements of the Privacy Regulations, I may use and disclose protected health information for purposes of complying with legal requirements, public health activities, reporting abuse, neglect, and domestic violence, cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations; for judicial and administrative procedures; for law enforcement; with respect to descendents; with respect to serious threats to health or safety; specialized government functions; and incident to use or disclosure otherwise permitted or required by the Privacy Regulations, as provided under the Privacy Regulations. I may also disclose protected health information, pursuant to your agreement, to persons indicated by you for involvement in your health care and for notification purposes.

Missouri State laws with respect to genetic information and to human immunodeficiency virus infection status are more stringent than the Privacy Regulations, and protected health information regarding these matters will be disclosed only in accordance with governing Missouri statutes.

You have certain rights with regard to the handling of your protected health information, as provided in the Privacy Regulations. These are as follows: You may request restrictions on certain uses and disclosures of protected health information, however, I am not required to agree to a requested restriction. You may receive confidential communications of protected health information as provided by the Privacy Regulations. You may inspect and copy your protected health information, pursuant to a written request, subject to certain restrictions in the Privacy Regulations, such as a restriction on access to psychotherapy notes. You have the right to appeal a denial of access to your records. You may request an amendment of protected health information and demographic information, pursuant to a written request, subject to certain limitations in the Privacy Regulations. You have the right to contest a denial of an amendment. You may receive an accounting of certain disclosures of protected health information. You may obtain a paper copy of this notice upon request.

You may complain to me and to the secretary of Health and Human Services if you believe your privacy rights have been violated. If you wish to contact me for further information, or to complain, you may do so at 636-388-2129. I will not take any action against you for filing a complaint or for exercising your rights under the Privacy Regulations.

Consent to Email Communication for Scheduling

As a convenience, you may use email to schedule or change an appointment. I check messages daily, unless I am out of the office, so make sure I have enough time to get and respond to your message. If you are unable to attend an appointment and fail to give 24 hours notice I'll have to charge for the time slot that was reserved for you unless other arrangements are made.

Please do not put any personal information in email. I do not do any clinical work through email or participate in email counseling.

If you would like to use email, please sign below to consent to the following statement:

I recognize that emails are not a secure means of transmitting or receiving data. Therefore, I understand the benefits and risks of email with this counselor and voluntarily wave my rights provided by federal and state laws regarding confidentiality in order to send to, or receive communications to and from Kelly Roberts via email. I voluntarily give my permission and will not hold Kelly legally responsible for the transmission of data via this means.

Client signature: ______________________________Date: _____________

Email address: ____

My email address is: klrddr2012@gmail.com.

Updated 2/27/2018