89 McCrory Drive
PO Box 856
Camdenton, MO 65020
573-525-7071 P
573-525-7072 F

119 N Benton St
PO Box 514
Waynesville, MO 65583
573-433-2833 P
573-433-2829 F

1030 Kingshighway
Suite A
Rolla, MO 65402
573-458-9920 P

General Intake Information (Adult)

Date: ________________

Client Name: ______________________________ DOB ____________ SSN: ____________

Current Physical Address: ____
Street City, State Zip Code

Current Mailing Address: ____
PO Box/Street City, State Zip Code

Permission To Contact By Phone & Email: The conversation in any phone or email transmission may contain certain confidential information pertaining to you. Disclosure of the information without written consent may be a breech of confidentiality. Please list the phone number(s) and email address we may use for setting up and/or rescheduling/ canceling appointments:

Mobile Phone ____________________ [] No Messages [] Voice Messages OK [] Text Messages OK [] Voice/Text OK
Home Phone ____________________ [] No Messages [] Voice Messages OK
Work Phone ____________________ [] No Messages [] Voice Messages OK

Consent for Electronic Communication

- I understand electronic communication should NOT be used in the case of a need for emergency care.
- I understand that refusal of this consent for electronic communication will not affect my ability to obtain treatment.
- I understand that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act.
- I understand that any email transmissions between my provider and myself will become part of my medical record.
- I understand that by providing an email address I attest that I control access to its information and that I may revoke this consent at time by contacting the provider.
- I understand that this service of electronic communication is offered solely at the discretion of the provider and may be withdrawn to the client at any time.

Email Address: ______________________________ Appointment Reminders: [] Yes [] No

I understand the information sent via electronic communication may include Private Health Information including information regarding diagnosis or mental health condition, and absolute privacy cannot be guaranteed. I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network. I hereby request electronic communication.

X____ ________________
Client/Guardian Signature Date

Insurance Information *or [] Self-Pay (If Using Insurance, must complete Permission to Treat)*

Member's Name ______________________________ Member's Employer ____________________
Insurance Carrier ______________________________ Group#________________________
Member ID ____________________ Members DOB ____________________ Copay _______
Client Relationship to Member: [] Self [] Child/Dependent [] Spouse [] Other

Emergency Contact____
Name Relationship Phone Number

Marital Status [] Single [] Married [] Other ____________________
Employment: [] Employed [] Full-Time Student [] Part-Time Student []Unemployed
Employer Name/Location: ____

 Modified 7/29/18 mw

Health Care Information

Name of Primary Care Physician/Clinic ______________________________

Date of last visit: __________ Reason: ______________________________

Month/Year of last physical: _____________ Health Status: [] Good [] Fair [] Poor

Informed Consent

Thank you for choosing Benton Street Counseling, LLC. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

COUNSELING is a collaborative process between you and the therapist to work on areas of dissatisfaction in your life and assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. The State of Missouri Board of Professional Counselors governs counseling activities. We do not take on clients that we do not think we can help; therefore, we will enter our counseling relationships with optimism about our progress.

RISKS: In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

CONFIDENTIALITY: As mental health providers in the State of Missouri, we are bound by the Missouri Code of Ethics. In accordance with these rules, information obtained in the counseling session or in written form will **not** be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary to "protect you or someone else from imminent harm" or is otherwise legally required and/or allowed by law (such as abuse of a child, elder, or disabled person or court order). If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties. Furthermore, if you want your insurance to pay for all or part of your treatment, we must be able to discuss your diagnosis and treatment with their representative.

Limits of Confidentiality

We are required to disclose confidentiality information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your counselor was appointed by the court to evaluate you.
4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing competence.
6. The contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office. If such a report is open to public inspection.
7. You are under the age of 16 and are a victim of a crime.
8. You are a minor and your counselor reasonably suspects that you are a victim of child abuse/neglect.
9. You are a person over the age of 65 and your counselor believes you are the victim of physical or emotional abuse.
10. You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.
11. You file a suit against your counselor for the breach of duty, or your counselor files a suit against you.
12. You have filed a suit against anyone and have claimed emotional/mental damages as part of the suit.
13. You waive your rights to privilege or give consent to limited disclosure by your counselor.
14. Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with your counselor.

CONSULTATION: Information about you will be discussed in confidence, without revealing your identity, with other counseling professionals among a multi-disciplinary team for the purpose of consultation and supervision for the intent of providing you the best possible service.

It is further acknowledged that my case may be reviewed and discussed with my supervisor in charge.

Therapist ____

Supervisor *(if applicable)* ______________________________________

By signing below I agree to participate in counseling services from the above named therapist and have authorized the release of medical information necessary for the purpose of treatment, payment, or any other healthcare operation pertinent to my health care.

X____ ________________

Client/Guardian Signature Date

FEES AND PAYMENT: Payment is due at the time of your session and can be paid with a valid check made payable to Benton Street Counseling, LLC, cash or credit card. The standard fee for initial sessions can range between $240 to $120 and each subsequent session can range from $200 to $80, however we at Benton Street Counseling, LLC do offer reduced session fees based on financial needs. Charges for counseling services will be discussed with your assigned mental health provider upon entering the contracted counseling agreement, and your income as well as your needs will be considered. There will be a returned check charge of $35 and we may no longer accept checks after a default check payment on an account.

In the event that the mental health provider in which you have been seeing is subpoenaed to testify or submit records to the court, a fee will be assessed for each of these services. For a written report, a minimum fee starting at $60 will be charged. For testifying locally, a fee of $100 per hour on site will be assessed. For testifying outside of Pulaski, Phelps or Camden County, travel fees (mileage), preparation time, in addition to fees for actual appearance, will be assessed.

APPOINTMENTS & CANCELLATIONS: Appointments are 45-50 minutes a session unless previously scheduled for a longer period. In most cases, initial appointments will be scheduled for a duration of 60-90 minutes, as there is much information to cover in the first session. If you are more than 15 minutes late, the session will be cancelled. If you are late, the session will not be extended and will end as scheduled.

When you make an appointment, you are reserving the therapist’s time, which means no one else is scheduled in that time period. Sometimes people are waiting for an available appointment time. If you find it necessary to cancel an appointment, please contact our office at least 24 hours in advance. The provider may also terminate counseling in the event the client has missed 3 appointments without calling to cancel 24 hours prior to the scheduled appointment. Failure to contact will result to charges incurred for your missed appointment.

SERVICES & FEES

Service	Fee	Unit
**Assessment	$240-120	Per Session
**Individual Counseling, Family and Couples Counseling	$200-80	Per Session
Group Counseling	$30	Per Session
*Classes (including materials)	Varies by class	
*Conference Call/Phone Contact (15 minutes)	$20	15 minutes
*Team Meeting	$50	Per Session
*Court Appearance (minimum charge of 1 hour, including wait time)	$100	Per Hour
*Home Study (including supporting documents and preparation)	$50	Per Hour
*Reports	$80 $100 $200	1-5 pages 6-10 pages 11+ pages
*Copies of Records	$23 + $0.54 per page	
*Supervised Visits/Therapeutic Visits	$40	Per Hour
*Travel Time for out-of-office services	$0.60	Per Mile
*Client UAs	$15	Per Transaction
*Non-Client UAs	$25	Per Transaction

**Sliding Scale fee available and varies by income and are reviewed every 3 months during treatment.
*Not covered by most insurance

An “hourly session” equals 45-55 minutes of face-to-face time.

Missed sessions will be billed to the client at the discretion of the therapist. A missed session is defined as not showing for a scheduled appointment and/or less than 24-hour notice for cancellations prior to scheduled appointment.

All reports require a client or parent/guardian signature to release confidential information to a third party. All copies require a written request.

Records Requests may take up to 4 weeks from the written request date to be processed.

I have read and understand all services and fees. I accept responsibility for payment of all services and fees.

X____ ____________________
Client or Parent/Guardian Signature Date

Client DOB: ______________________________ Client SSN: ____________________________________

EMERGENCIES/CRISIS/AVAILABILITY: When you have difficulty, try using tools and information you have learned. If you need immediate help for a crisis or emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately.

I have read, understood, agree, and consent to the above conditions of service stated. I have also received the notice of privacy practices on this date and have had the opportunity to ask questions about and understand these policies.

X____ ____________________
Client Signature Date