COMPASS
COUNSELING & PSYCHOLOGY SERVICES

7984 New LaGrange Road
Louisville, KY 40222

502.426.2777
502.426.2776
compasscaps.com

Child / Adolescent - New Client Information Form

1 Contact Information

Child's First Name: Last Name:

Street Address:

City: State: Zip Code:

Telephone: DOB: / /

Gender: ○ Male ○ Female Race: ○ AA ○ Asian ○ C ○ H ○ Mul ○ Other

Child's School: Grade: Age:

Who Referred You to Our Practice:

Parents

Parents' Relationship Status: ○ Married ○ Cohabitate ○ Separated ○ Divorced ○ Widowed ○ Never

If parents are living separately, who has custody and what is the current visitation schedule:

Parent 1

Name: DOB: / /

Address:

Employer: Employer Phone:

Best Phone: Work Phone:

E-Mail Address:

Preferred Method of Contact: ○ Phone ○ E-Mail ○ Post

Marital Status: Stepparent's Name (if applicable):

Parent 2

Name: DOB: / /

Address:

Employer: Employer Phone:

Best Phone: Work Phone:

E-Mail Address:

Preferred Method of Contact: ○ Phone ○ E-Mail ○ Post

Marital Status: Stepparent's Name (if applicable):

2 Insurance Information *(if applicable)*

Insurance Co. Name: Employer:

Subscriber's Name Subscriber's Phone:

Subscriber's Address: Relationship:

City:

State: Zip Code:

Telephone: Subscriber's Date of Birth:

ID / Member #: Group #:

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3 Informed Consent For Treatment

Welcome to The 12 Sherpas PLLC (DBA Compass Counseling & Psychology Services). This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

FOR MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request a verbal agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

PLEASE NOTE: ***KENTUCKY STATE LAW REQUIRES THAT INDIVIDUALS 16 AND OVER MUST CONSENT FOR MEDICAL TREATMENT.***

IF YOUR CHILD IS 16 OR ABOVE, HE/SHE MUST ALSO SIGN THIS FORM.

MEETINGS

I normally conduct an intake evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one session (one clinical hour of 45-50 minutes duration) per week, at a time we agree on. However, some sessions may be longer or we may meet more or less frequently. Once an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours (1 day) advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. Please do not come to the office sick—this fee is waived in the event of illness or other circumstances at the discretion of Compass Counseling & Psychology Services. Work, school and/or social obligations are not considered circumstances beyond your control. Insurance does not pay for missed sessions.

NATURE OF THE WORK

The process of undergoing therapy can be like a journey. Often times, people feel worse before they feel better. This is the nature of the work. However, because this is not an exact science, there are also no guarantees. It is important to have reasonable expectations when beginning the difficult but rewarding process of making changes in your life. The way I am able to help you the best depends on regular meetings over time. It is my expectation that you will come to therapy even if you cannot think of anything to say. If you are unable to make the majority of our scheduled meetings, I may recommend referral to another provider. If you feel our work together is unsatisfying, please discuss it with me. Together we can determine if modifications to the treatment can be made, or if it is best for me to refer you to another provider.

THERAPEUTIC RELATIONSHIP

The relationship between a mental health provider and the client is unique. It is similar to a relationship you may have with a trusted friend or confidante in that you will likely share very personal information with me. You may even relate things to me that you have never told anyone else. I value your trust in me with this sensitive information. However, the therapeutic relationship is different from a friendship in that it is one-sided. Generally we will not discuss my life and you are not expected to "be there for me." A mental health provider's code of ethics strictly forbids socializing with clients, accepting gifts of significant value from clients, connecting on social media sites, and other behaviors that can be potentially harmful psychologically to the client.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. I work with a benefits administrator who is in charge of pre-authorization and billing of sessions for clients who use their insurance benefits. However, I am not on every insurance panel so it is important that you verify my participation on your network if you will be using your insurance benefits. Ultimately, you are responsible for maintaining coverage through your health insurance.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office on weekdays, I probably will not answer the phone when I am with a client. When I am unavailable, our administrative team answers phone calls and emails and when they are unavailable, a voice mail records messages. The voice mail is monitored between 10 AM and 4 PM, Monday through Thursday. I will make every effort to return your call within 24 business hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. For a quicker response, please email info@compasscaps.com or me directly. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911 or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist are protected by law, and I can only release information about our work to others with your written permission. My general rule should we see each other outside the office is to not indicate I know you, unless you acknowledge me. To prevent a possible breach in confidentiality with awkward introductions, please avoid approaching me in public if I am with someone else.

There are a few exceptions to the rule of confidentiality. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. I will inform you if I receive a subpoena for your records. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. Additionally, filing insurance claims with your insurance provider, though they contain little clinical information, constitutes confidential protection.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly or disabled person, or another vulnerable adult is being neglected or abused, I am

required to file a report with the appropriate state agency. By law health care providers MUST report these situations, without exception.

If I believe that a client is threatening serious bodily harm to another person or group of persons, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. By law health care providers MUST report these situations, without exception.

While I am trained to handle a psychological crisis, fortunately these situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I understand and agree that all communication between this office and the client is held in strictest confidence UNLESS one of the following conditions is met:

- the client utilizes his/her insurance benefits
- the client authorizes release of information with a signature
- the provider is ordered by a court to release the information
- threats to harm self/others are made by the client
- abuse or neglect is suspected. In the latter two cases, the provider is required by law to inform legal authorities and/or potential victims.

I _____ (print name of patient) agree and consent to participate in mental health services offered and provided by a mental health provider on Compass Counseling & Psychology Services staff.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Additionally, you acknowledge access and receipt of Compass Counseling & Psychology ServicesNotice of Privacy Practices, which can also be found on http://www.compasscaps.com.

Signature

Client Signature	Date:	Parent/Guardian Signature	Date:
Client's Printed name		Parent/Guardian Printed Name	
Compass Counseling & Psychology Services Staff	Date:		

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4 Professional Fee Policy

Charges for services are due and payable in full at the time the services are rendered. If you have health insurance coverage, a claim form will be filed on your behalf. In the event the insurance rejects your claim, or the amount paid is less than the charges, you are responsible for paying the balance owed on your account immediately. Your account can be settled using cash, check or credit card.

In the event you are unable to pay your bill in its entirety, please contact the office to make arrangements. Financial disagreements regarding child custody, divorce or other situations do not impact the below-signed individual's financial agreement with this office. Bounced checks are subject to a service fee of $25.00 per item. If a statement remains unpaid after sixty (120) days and no satisfactory arrangements have been made, the account will be sent to collections or small claims court. The cost of these proceedings will be included in the claim.

Your appointment time is reserved especially for you and you must cancel with 24-hours notice to avoid a cancellation charge. If you cancel without 24-hours notice or no show an appointment, you will be charged the amount of your contracted insurance rate. Please do not come to the office sick—this fee is waived in the event of illness or other circumstances at the discretion of Compass Counseling & Psychology Services. Work, school and/or social obligations are not considered emergencies.

There is a $25.00 charge for each fifteen (15) minutes of a telephone consultation lasting longer than five (5) minutes. Matters requiring lengthy email responses are billed at the same rate. There is a $50.00 charge for each fifteen (15) minutes of the clinician's time required for filling out paperwork related to disability claims, etc. Clients requesting a copy of their record may be expected to pay a $0.50 per page fee. Insurance companies will not pay for these fees. (Paperwork required by your insurance company for services rendered is *not* subject to this fee.)

If you become involved in legal proceedings that require my participation, you will be responsible for my professional time. Because of the difficulty of legal involvement, you are expected to pay a flat fee of $800.00, which covers the first two hours of court or deposition appearance and one hour of preparation time/phone calls. An administrative fee of $100.00 is also required. Additional time will be billed at $200.00 per hour for preparation work and $450.00 per hour for attendance at any legal proceedings. Insurance companies will not pay for this fee.

By signing below I attest that I understand and agree to the professional fee policy. I am aware that I am ultimately responsible for any charges incurred for services rendered. It is my responsibility to inform this office of any changes to my insurance or billing information.

Signature

Patient or Representative Signature

Date:

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5 Electronic Communication Consent Form

Electronic communication offers an efficient way to communicate with Compass Counseling & Psychology Services staff. However, this medium is not without its risks. Communication by telephone, cell phone, text, mail, email, websites, fax, and the like are not secure and thus do not guarantee confidentiality. Though I take many steps to protect confidentiality, if you choose to contact me via one of these methods, you are accepting the risk that a third party may intercept our communication. Compass Counseling & Psychology Services will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct.

GUIDELINES FOR USE OF ELECTRONIC COMMUNICATION

- Email, phone calls and/or texting is not appropriate for urgent matters or an emergency situation; instead please call 911 or go to your nearest emergency room.
- Emails and texts should be concise. You should schedule an appointment if the issue is too complex or sensitive to discuss via these mediums. Email messages will be filed electronically in the patient record.
- Compass Counseling & Psychology Services staff members typically check messages on a regular basis, however there may be exceptions to this. Most calls are returned by the end of the next business day.
- Compass Counseling & Psychology Services staff members will not forward patient identifiable emails to others outside this practice without the patient's prior written consent, except as authorized or required by law and we will never distribute a patient's email address to a third party.
- Compass Counseling & Psychology Services is not liable for breach of confidentiality caused by the patient or any third party.
- Normally, there will be no charge for use of periodic, brief emails or texts. Should a message require a lengthy response, regular correspondence rates will apply (see Professional Fee Policy).
- Inform your provider of changes in your contact information including email and phone numbers.
- Please do not give your psychologist/therapist's email address to a third party.
- Please do not request contact or connection with your therapist via social media sites such as Facebook or Linked In. This is potentially a violation of your confidentiality and outside the boundaries of our relationship.
- Please do not forward emails, jokes, etc. to your clinician's email address. Email is reserved for business matters only. Abuse of this will result in the patient being billed at the regular correspondence rate.

Signature

Patient or Representative Signature _____ Date: _____

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6 Canine Assisted Therapy Awareness Form

PROGRAM: I am aware that two clinicians at Compass Counseling & Psychology Services , Amy B. Greenamyer, PhD and Christina Bayens, PsyD, use a canine assisted therapy program. Information about the dogs, including photos, is available on our website: www.compasscaps.com

BENEFITS: I understand that this type of program has been instituted in other patient care settings and that studies have shown that pets can have a beneficial effect on health and well-being—providing companionship, love, and emotional responsiveness.

RISKS: I am aware and have been informed of the fact that a live, domestic dog will be available in Compass Counseling & Psychology Services offices, but will not be in session with therapists other than Dr. Greenamyer or Dr. Bayens. I understand that the behavior and reactions of animals are not predictable, and therefore, Compass Counseling & Psychology Services cannot guarantee that the dog will behave properly or that the dog will not bite, claw, scratch or otherwise inflict injury.

I, also, am aware of no allergy, skin or respiratory sensitivity or other medical condition that I have which might make touching, handling or being in close proximity to the dog potentially harmful to my health. At my request, Compass Counseling & Psychology Services staff will see me in another room of the building if proximity allergies exist.

AGREEMENT: I have been assured that Dr. Greenamyer and Dr. Bayens have both carefully selected their dogs and that the dogs have never shown any vicious tendencies heretofore. The dogs are up to date on all vaccinations and will never be in session if ill or injured. The dogs in the office will be supervised at all times by their owner/handler.

If I choose to greet either Dr. Greenamyer or Dr. Bayens' dogs while I am at Compass Counseling & Psychology Services , I agree to handle these animals gently. I will try to avoid provoking an angry response from them. I agree to assume the risk of any injury or illness resulting from my participation and agree to hold The 12 Sherpa's PLLC (DBA Compass Couseling & Psychology Services), Drs. Greenamyer and Bayens, and the building owner, Hangar 116 Holdings, LLC harmless for the actions of the dogs used in this program.

Signature

Patient or Representative Signature

Date: