KIM SMALL, LPC
Professional Counselor

397 Little Neck Road
Building 3300, Suite 230
Virginia Beach, Virginia 23452
KIM@KIMSMALLCOUNSELING.COM
757.354.4008 (O)

PROFESSIONAL SERVICES AGREEMENT

PATIENT NAME _____ **PATIENT DATE OF BIRTH** _____

ABOUT YOUR COUNSELOR

I am a Licensed Professional Counselor in Virginia (License: 0701005889). My treatment method combines various interpersonal, family systems, cognitive-behavioral, and trauma-focused ideas. I believe people are resilient, and have a tremendous ability to address their life situations. I often use a therapeutic approach called EMDR to assist in doing this, which is designed to help resolve past distressing events. I also utilize the Enneagram as a tool to help clients understand habitual ways of engaging in the world and to facilitate growth. It is my role as a therapist to help you understand the dynamics of your situation and to help you use you particular strengths to address issues and concerns. Believing the therapeutic process is one that is interpersonal and collaborative in nature, I tailor sessions to meet the individual needs of you and your family.

I am also a Clinical Christian Counselor, which means I believe Jesus Christ is the Son of God, and that by believing this, anyone may have eternal life in His name (John 5:24). While my beliefs impact and shape the work I do with clients, I realize that you may not share my beliefs. It is my hope to be of help to you regardless of your religious orientations or personal beliefs. If your spiritual beliefs differ from mine and this is a concern for you, please discuss this with me at the beginning of therapy.

I, _____, (Patient OR parent/guardian of minor client, under 18)

_____ **Have read and understand** the contents of the Virginia Notice Form (A copy of this will be provided upon request.) regarding the Protected Health Information (PHI) held by Kim Small, LPC for requested services. I understand this information will be handled in accordance with the HIPPA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI.

_____ **Give Informed Consent to Treatment:** My consent indicates a commitment to enter into treatment with the initial understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation these goals may change to best serve my long-term interest.

_____ **Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

_____ **Understand the Counselor Limits of Confidentiality**: Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The patient threatens suicide or physical harm to another person(s), including murder or assault
2. The patient reports suspected abuse of a minor child (under18), or the elderly including but not limited to physical beatings and sexual abuse.
3. The patient reports sexual exploitation by a therapist.
4. The court orders the therapist to testify or release records to the court.
5. The patient threatens or causes property damage to the counseling center or therapist's property.

State law mandates that mental health professionals may need to report any of the above situations to the appropriate person and/or agencies. Communication between the counselor and patient will be confidential as stated under the laws of this state.

6. Billing Administration: You understand that I use Shawnea Roberts for billing purposes and authorize communication with her for such purposes. Insurance companies and other third party payers are given information they request regarding services to clients. Information that may be requested includes, but is not limited to, types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
7. Professional Consultation: You understand I regularly consult with Rachel Harner, LPC and Leigh Ellen Rodriguez, LPC; however, all identifying information will remain protected.

_____ **Understand** I do not provide 24-hour on-call services for problems you may be experiencing. ***Should you have a mental health emergency, you agree to visit your local emergency room or police department. If you cannot get there on your own, you should dial 911 or call 757-362-LIFE (5433).***

- I work to return messages by the end of the next business day. I cannot respond to every email between sessions, but will work hard to respond in a timely manner. Text Messaging is *not* an appropriate venue for discussing therapeutic issues, as confidentiality cannot be guaranteed in any communication in written electronic form. However, it may be used for scheduling.
- Office hours: Monday - Wednesday from 8:00am to 5:00pm. I can be reached at 757-354-4008 or Kim@KimSmallCounseling.com.

Consent to Contact: In accordance with the HIPAA Privacy Rule, we cannot leave a message for a patient unless we have your consent. Please **initial one** of the following statements to indicate your preference for contact.

_____ **You MAY contact** me by phone for appointment reminders or to notify me of a cancellation by leaving a phone message or text at the following #.

_____ _____
(home) (cell)

_____ **You MAY NOT** contact me by phone for appointment reminders or notify me of cancellations by leaving a phone message.

_____ **Understand** appointment reminders are a curtesy and not guaranteed. I am responsible for keeping scheduled appointments. I understand that a missed appointment fee will be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient or Responsible Party (if minor) Date

_____ _____
Name of Responsible Party (if minor) Relationship to Patient

Witnessed by Kim Small, LPC _____ *Date* _____

FINANCIAL POLICY

KIM SMALL, LPC

I believe that a clear understanding of our financial policies is important for both client and therapist. I am fully committed to helping you accomplish the goals you establish when you enter counseling and to help you maximize your investment of time and finances. I will deal with you fairly, equitably and with sensitivity to financial matters. The following information clearly demonstrates our financial policies. A copy for your records will be provided upon request.

PATIENT NAME _____ **PATIENT DATE OF BIRTH** _____

Insurance Information: Insurance is a contract between you and your insurance company. It is your responsibility to know your benefits before you receive services. If your insurance company requires a referral or preauthorization you are required for obtaining that. You authorize payment to be made on your behalf to the practice for any services provided to you.

- **I agree to pay my co-payments, coinsurance, and/or deductible at the time of service**.
- Patients are responsible for any outstanding balance in the event that the insurance carrier denies coverage, benefits, changes co-payment, adjusts your deductible, retracts a payment, or does not provide benefits as estimated.
- Patients must notify our office of any changes to their insurance at least 48 hours prior to an appointment or patient may be responsible for the full standard fee for that appointment.

Payment Information: I understand that full payment is due at the time of service, including co-payments, coinsurance, and/or deductibles, standard-rates, and missed appointment/late cancellation fees.

- I understand the **standard rate is $120 per session** if I do not utilize insurance benefits.
- Credit cards, cash, or checks to KIM SMALL, LPC are accepted.
- *I understand that credit cards used for payment will be kept securely on file.* **I authorize Kim Small, LPC to charge the card on file for payment of service.**
- A $5.00 billing fee will be applied each month to any account that carries a balance requiring a statement after 30 days. Patients will be charged $35.00 for a return check or returned credit card payment.
- There is a charge for services that are not routine in mental health treatment. Such services include, but are not limited to, written consultations and telephone consultations, collaboration with other professionals at your request, working with your child's school, engagement in any legal or court proceedings.

Past Due Account: If your account becomes past due we will take the necessary steps to secure payment. You understand that if your account is referred to a collection agency that you will be responsible for all fees (including collection, lawyer and court costs) associated with this process. You understand that if your account is submitted to an attorney or collection agency your status as a client and that you received treatment from me may become a matter of public record. *This will result in a waiver of confidentiality.*

Rescheduling Appointments; Missed Appointment: Missed or canceled appointments delay our work together and interrupt the therapeutic process. Additionally, your time is reserved for you and prevents someone else from scheduling.

- Cancellation is required at least **24 business hours before** the start time of the appointment. For example, if the scheduled appointment is on a Monday at 10 a.m., then the client must reschedule the appointment by no later than 10 a.m. on the preceding Friday. Please cancel via email at Kim@KimSmallCounseling.com or by call/text at 757.354.4008.
- **Missed appointment fees are not covered by insurance and are the responsibility of the patient. I understand the missed appointment fee will be charged to my credit card on file.** They will reflect the **full fee for your session,** not your copay or coinsurance.
- **Fees will not be waived in any event** for a missed appointment.
- If cancellation/rescheduling is frequent or consecutive I will assume that your time is not working for you. You will lose your weekly time but are welcome to continue scheduling based on appointment availability. If a client misses more than four (4) appointments, I may proceed to take such steps necessary to terminate the therapeutic relationship.

I accept financial responsibility for the patient account and the terms of the payment agreement.

Name of Patient/Responsible Party (if minor):: _____ Date: _____

Signature: _____ Relationship to patient: _____

Witnessed by Kim Small, LPC _____ **Date** _____

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CREDIT CARD AUTHORIZATION AGREEMENT

PATIENT NAME _____ **PATIENT DATE OF BIRTH** _____

I, _____, authorize Kim Small, LPC to use my credit card information to charge my credit card for:

- Copayments
- Deductible amount determined by your insurance company
- Therapy session that you have authorized and not covered by insurance
- Cancellation/missed appointments less than 24 hours in advance (business day).
- Or, if a check is returned for any reason.

I authorize credit card charges for the following members: _____
_____ _____

I will not dispute charges ("charges back") for session I have received, authorized or appointments I have missed according to the above policy or the policy of Kim Small, LPC. I will not dispute charges if I submit another charge card in my name. I agree to update card information if that card is replaced for any reason.

Card Type (circle one): VISA MasterCard Discover AMEX

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____ Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

By signing below, I am authorizing Kim Small, LPC to charge for missed and scheduled appointments, copays, authorized services, and deductible amounts.

_____ _____
Signature Date

KIM SMALL, LPC
PROFESSIONAL COUNSELOR

397 LITTLE NECK ROAD, BUILDING 3300, SUITE 230
VIRGINIA BEACH, VIRGINIA 23452

KIMSMALL.LPC@GMAIL.COM
757.354.4008

CLIENT INTAKE FORM

CLIENT INFO

Date of Birth: ___/___/___ Age: _____ M / F

Name:_____

Address:_____

City:_____

Home:_____ Cell: _____

Work:_____ Other:_____

On what number may I leave a confidential message:

____ Home ____ Cell ____ Other

How were you referred to me? _____

EMPLOYER & STATUS

Employer: _____

I am: ___self-employed ___unemployed ___retired

I am: ___single ___married ___divorced

How many people live in your household? _____

Religion as a child: _____

Religion currently: _____

Counseling history:

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications: _____

SYMPTOM ASSESSMENT

I AM EXPERIENCING:	NEVER	SELDOM	OFTEN	ALWAYS	HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					

Phobias: unsual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about trauma					
“Flashbacks” as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I am Feeling:	Never	Seldom	Often	Always	how long?
Decreased interest in pleasurable activities					
Social isolation, Loneliness					
Suicidal Thoughts					
Non-suicidal self-injurious thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I Notice:	Never	Seldom	Often	Always	how long?
I am angry, irritable, hostile					
I feel euphoric, energized, and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I Have:	Never	Seldom	Often	Always	how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					

Been hearing voices when alone					
Problems with my speech					

I Have:	Never	Seldom	Often	Always	how long?
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequences					
Been physically harming myself					
Been violent toward others					

I Use the Following:	Never	Seldom	Often	Always	how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

My Eating Involves:	Never	Seldom	Often	Always	how long?
Restriction of food consumption					
Bingeing and/or Purging					
Binge Eating					
A lot of weight loss or gain					
Excessive exercise in response to food consumption					

Employment & Self-Care:	Never	Seldom	Often	Always	how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood related relatives.

My Family Has A History Of:	Yes	No	Who
Alcoholism and/or drug dependence			
Anxiety			
Depression			
Bipolar Disorder or distinct changes in behavior or mood			
Eating disorders			
Phobias			
Suicidal behavior			

Please note any other medical or emotional problems with similar symptoms to yourself.

What is the Major concern that led you here today?

What do you consider your strengths?

What do you consider your weaknesses?

What do you hope to gain from therapy?

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

Signature: _____ Date: _____

KIM SMALL, LPC

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VIRGINIA BEACH, VA 23452
KIM@KIMSMALLCOUNSELING.COM
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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the COVID 19 or if other concerns and safety protocols arise, I may require that we meet via Telehealth. If you decide at any time that you would feel safer returning to Telehealth services, we will discuss your options regarding this transition based on what is clinically appropriate per my professional assessment and recommendation.

Financial Responsibility

Please be advised you are responsible for ensuring your insurance plan covers Telehealth for outpatient mental health/behavioral health sessions with me as the provider. While many insurance plans have provided exceptions and allowed for Telehealth during the COVID 19 pandemic, I do not know the details of your specific plan and when/if those allowances will end. You assume all financial responsibility in the event we begin or return to Telehealth services based on your decision or mine.

You understand that the normal cancelation policy, which requires 24-business hours notice to cancel, applies. Telehealth may not be used as a last minute option to attend your appointment unless COVID-19 symptoms or exposure are present.

Risks of Opting for In-Person Services

You understand by coming to the office you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel, travel by public transportation, cab, or ride-sharing service, opt to not wear a mask, or opt not to practice social distancing.

Initial: _____

Date: _____

By initialing you are indicating you independently are making a decision to meet face-to-face, agree to the above in Decision to Meet Face-to-Face, Financial Responsibility, and Risks of Opting for In-Person Services sections and understand that at any time I may request our sessions begin/resume via Telehealth based on my assessment of risk and/or local, state, and federal policies. If you decide you do not want to begin/resume Telehealth or if I determine it is clinically inappropriate for your treatment to begin/resume Telehealth, I will refer you to another qualified provider.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure. If you do not adhere to these safeguards or circumstances change which put you at higher risk of exposure per my assessment, it may result in our starting/returning to a Telehealth services based on guidelines agreed to above. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are **completely** symptom free. _____
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using Telehealth. _____
- You will wait in your car or outside until no earlier than 5 minutes before our appointment time. _____
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. The bathroom is immediately to the right of the elevator when you exit the elevator. _____
- You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. _____
- You will wear a mask in all common areas of the office if you are not fully vaccinated. _____
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me or others. _____
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately let me know. _____
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. _____
- If you or someone you live with tests positive for the infection, you will immediately let me know and we will then begin/resume treatment via Telehealth if feasible and clinically appropriate. _____

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes and I will provide those changes in writing.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other

symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by Telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have tested positive for the coronavirus, I may be required to notify my local health authorities that you have been in the office. If I have to report this information, I will only provide the minimum information necessary for their data collection, which may include your contact information, and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____	_____	_____
Client's Signature	Printed Name	Date
_____	_____	_____
Guardian's Signature	Printed Name	Date
_____	_____	_____
Provider's Signature	Printed Name	Date