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 $110 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

Teletherapy Consent

Kim Small, LPC

Patient Name _____ **Patient Date of Birth** _____

Phone: _____ **Email:** _____

Technology "How To": Most clients "opt-in" to receive invitations to sessions via email or text. If this is the case for you, you'll receive an email notification, either directly from me or from my HIPAA compliant video software, SecureVideo, to begin online sessions. I encourage clients to do a test log in prior to our appointment to make sure that everything is working well on their side. You can check that your mic, speakers, and video are working. Please note: None of our sessions will be recorded.

Additional Tips and Awareness About Teletherapy:

- If this is your first appointment, I will ask you to hold up identification to the camera so I confirm that it is you. This is a legal and ethical consideration as part of providing means through online therapy.
- If your location is different from your usual spot, I will need to know, in case of an emergency.
- If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to the session. I cannot legally guarantee confidentiality on your end of the teletherapy session.
- Turn off notifications on your computer and phone once we are connected.

Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication: Communication with me via any online or electronic means is limited in security and thus your confidentiality may not be guaranteed. I use secure and encrypted (HIPAA compliant) video software for our sessions, SecureVideo. I use secure email and phone systems. However, I want you to be aware that if you do not also use secure/encrypted programs on your side of the communication, the communications may not be secure. Security laws (HIPAA laws) state that clients have the freedom to request or "opt-in" to less secure means of communication if they are aware of the risks, comfortable with them, and find it clinically helpful to do so. Please consider the limits of confidentiality in electronic communications. Ensure that you too are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy.

1. I attest that I will utilize the means of online or teletherapy in order to access therapy with my therapist.
2. I understand that my therapist is an independent practitioner; therefore, the vendors/providers she contacts with (video software, messaging software, billing software, documentation software, etc.), are not responsible for or involved in my care or treatment.
3. I attest that the video conferencing, phone conferencing, or digital conferencing technology will be used and that it is not the same as a direct client/mental health care provider visit, due to the fact that I will not be in the same room as my therapist.
4. I understand that a teletherapy treatment has potential benefits, including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist may discontinue the teletherapy session if it is felt that the tele means of connection are not adequate for the situation.
6. I understand that teletherapy treatment with my therapist is not an Emergency Service. If I experience a life-threatening emergency, I will call 911, go to the hospital, or implement my developed safety plan.
7. I agree to end each teletherapy session by hitting the "leave session" button and fully close my browser to help ensure my confidentiality.
8. I understand that my therapist cannot guarantee confidentiality in teletherapy due to limits in security on the client's side of the session and I will do my best to ensure I am using secure measures including: turning off other services, applications, programs, and websites from running on my devices during the session and being in a private location.

Client acknowledgement and agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. In addition, I have chosen to opt in to Telehealth. I further waive any and all claims that may arise against Kim Small, LPC resulting from the use or misuse of text SecureVideo teletherapy.

Signature of Patient: _____ Date: _____

Signature of Responsible Party (if minor): _____

KIM SMALL, LPC

397 LITTLE NECK ROAD, SUITE 230
VIRGINIA BEACH, VA 23452
KIMSMALL.LPC@GMAIL.COM
757.354.4008 I 757.512.8041 (FAX)

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

I, the undersigned, do hereby authorize you to:

( ) Furnish records TO Kim Small, LPC from: _____

( ) Furnish records FROM Kim Small, LPC to: _____

Please initial to Specifically Authorize the use and/or Disclosure of (initial each requested item):

( )	Emergency Room/Urgent Care Records	( )	Admission Notes
( )	Hospital Records (Nursing & Progress Notes	( )	Discharge Summary
( )	Initial Psychiatric Evaluation	( )	Clinical Summary
( )	Medication History	( )	Psychological Test Reports
( )	Outpatient Progress Notes	( )	Verbal Discussion of Care
( )	Consultation Reports	( )	Written Reports to Coordinate Care
( )	Laboratory Results	( )	Billing Statements
( )	Other (specify)		

The requested records or information is about health care provided during the following approximate time frame: _____ to _____

The purpose of this disclosure is (Please check): ( ) Coordination of Care ( ) Transfer Care

( ) Other (specify): _____

The authorization expires on: ( )_____ ( ) A year from this date.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations. The use of disclosure requested under this authorization will result in direct or indirect remuneration to Kim Small, LPC.

I understand that I can revoke this authorization at any time in writing to Kim Small, LPC.

I understand that Kim Small, LPC cannot condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless treatment is related to research and the purpose of this authorization is to engage to protected health information described abuse to be used for such research.

I have received a copy of this authorization: _____ Yes _____ No

Patient Signature: _____ Date: _____

Relationship/authority (if signed by authorized representative): _____

Witness Signature: _____ Date: _____

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CLIENT INTAKE FORM
(CHILD/ADOLESCENT)

PARENTS PLEASE COMPLETE PG 1-4 AND HAVE YOUR TEEN (AGE 12-17) COMPLETE PG 5-6

CLIENT INFO

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

Name:_____

Address:_____

City:_____

How were you referred to me? _____

Home:_____ Cell: _____

Work:_____ Other:_____

On what number may I leave a confidential message:

____ Home ____ Cell ____ Other

Religious Preference: _____

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

CURRENT HOUSEHOLD & FAMILY INFO

Name	Relationship to Client	Age	Gender	Living with you?	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

PARENT'S MARITAL STATUS

Single Married Divorced Divorce in process Widowed Other

If divorced, how old was your child at the time of divorce? _____

For Parents who are divorced, please state custody arrangements.

Is the child's other parent/guardian aware that you are bringing your child to counseling today? Yes No
If no, please explain.

Biological Father's Name: _____

Address:_____ Phone: _____

Assessment of current relationship with your child? Poor Fair Good

If divorced, have you remarried? Yes / No

Biological Mother's Name: _____

Address:_____ Phone: _____

Assessment of current relationship with your child? Poor Fair Good

If divorced, have you remarried? Yes / No

Health and Medical

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications: _____

If you answer yes to any of the questions below, please describe:

Were there any complications with the pregnancy or delivery on your child? Yes No

Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes No

Has your child experienced any emotional, physical, or sexual abuse? Yes No

Counseling History

Previous counselor: _____

For what reason did your child attend counseling?

What did you find MOST helpful in therapy?

What did you find LEAST helpful in therapy?

Parent Assessment

Please CIRCLE any symptoms you see is your child/teen and indicate if they are Mild, Moderate, or Severe

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sadness				Appetite changes			
Crying				Social Isolation			
Sleep Disturbances				Paranoid Thoughts			
Dissociation				Poor Concentration			
Hyperactivity				Indecisiveness			
Binging/Purging				Low Energy			
Loneliness				Excessive Worry			
Guilt				Low Self-esteem			
Irritability				Anger Issues			
Nausea/Indigestion				Spiritual Concerns			
Social Anxiety				Hallucinations			
Self-Harm				Racing Thoughts			
Cutting				Restlessness			
Impulsivity				Drug Use			
Nightmares				Alcohol Use			
Hopelessness				Tabacco Use			
Elevated Mood				Easily Distracted			
Mood Swings				Trauma Flashbacks			
Disorganized				Obsessive Thoughts			
Anorexia				Panic Attacks			
Grief/Loss				Feeling Anxious			
Phobias				Feeling Panicky			
Headaches				Suicidal Thoguhts			
Weight changes				Past Suicide Attempts			
Work/School Issues				Problems at home			
Decreased Creativity				Risky Behavior			
Oppositional/Defiant Behavior				Other			
Excessive Exercise				Other			
Loss of Interest				Other			

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

There is a Family 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			

What is the major concern that led you here today?
What do you consider your child's strengths?
What do you consider your child's weaknesses?
What do you hope to gain from therapy?

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

Guardian Signature _____ Date _____

Adolescent Assessment (ages 12-17)

Personal Strengths

What activities do you enjoy and feel you are successful at when you try?

Please CIRCLE any symptoms you are experiencing and indicate if they are Mild, Moderate, or Severe

Who are some of the influential & supportive people, activities, or beliefs in your life?

Current Reason for Seeking Counseling

Briefly describe the problem for which you are seeking to have counseling for.

What would you like to see happen as a result of counseling?

Counseling History

Have you previously seen a counselor? Yes No

What did you find MOST helpful in therapy?

What did you find LEAST helpful in therapy?

Family History

Are your parents married or divorced? Married Divorced Other

Do you think their relationship is good? Yes No Unsure

If divorced, who do your primarily live with? _____

What's your relationship with your mom like? Poor Fair Good

What's your relationship with your dad like? Poor Fair Good

Did you experience any abuse as a child/teen in your home or outside your home? Yes No
Please describe as much as you feel comfortable

	Mild	Moderate	Severe		Mild	Moderate	Severe
Family Concerns (Please circle any family concerns you have)							
Fighting				Education problems			
Feeling distant				Financial problems			
Loss of fun				Death of family member			
Lack of honesty				Abuse / Neglect			
Physical fights				Feeling unsafe			
Job change/dissatisfaction				Desagreeing about relatives			
Disagreeing about friends				Alcohol use			
Drug use				Other			
Marriage issues				Issues regarding remarriage			
Birth of a child				Birth of a sibling			

Individual Concerns

Hyperactivity				Indecisiveness			
Binging/Purging				Low Energy			
Loneliness				Excessive Worry			
Guilt				Low Self-esteem			
Irritability				Anger Issues			
Nausea/Indigestion				Spiritual Concerns			
Social Anxiety				Hallucinations			
Self-Harm / Cutting				Racing Thoughts			
Loss of Interest				Restlessness			
Impulsivity				Drug Use			
Nightmares				Alcohol Use			
Hopelessness				Tabacco Use			
Elevated Mood				Easily Distracted			
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Anorexia				Panic Attacks			
Grief/Loss				Feeling Anxious			
Phobias				Feeling Panicky			
Headaches				Suicidal Thoguhts			
Weight changes				Past Suicide Attempts			
Excessive Exercise				Grade Changes			
				Other			

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

Client Signature _____ Date _____