Kaleo Counseling Services

5498 St. Charles St. **636-447-0100** **8050 Watson Rd. Ste 335**
Cottleville, MO 63304 **St. Louis, Mo 63119**

COUPLES CONSENT & CONFIDENTIALITY CONTRACT

We understand that couples therapy begins with an evaluation of our relationship, past and present. While our therapist at Kaleo Counseling Services, LLC is deciding whether he/she is the appropriate therapist for us, we will decide whether we wish to begin couples therapy with him/her. We understand that because of the commitment of time and money, plus the potential impact on us and others, it is important to make an informed choice for a couples' therapist.

We understand all policies as described on the INFORMED CONSENT and accept them as conditions for entering into couples therapy with our Kaleo Counseling Services, LLC therapist. We understand the limits and benefits of using insurance to pay for couples therapy. If we use insurance, we agree to provide all information needed to comply with insurance regulations. We understand that if we use insurance, our therapist will not retain control over information provided to the insurance company. We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with our therapist. We understand upon our therapist's discretion, information shared individually with therapist may be shared with the spouse/partner during a subsequent couple session.

We agree to share responsibility with our therapist for the therapy process, including goal setting and termination. By entering into couples therapy, we accept that we both and understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. [This is especially true if we have dependent children.

We agree to pay for all services provided by our therapist. We understand that no insurance company will pay for missed sessions, and we agree to the Kaleo Counseling Services, LLC policy of charging if we fail to cancel appointments in advance.

It is understood by both parties that in utilizing Kaleo Counseling Services, LLC for therapy, they are expected not to use information given to the couples' therapist during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit.

The signatures below reflect that the parties agree to the terms set forth above.
Signature of client(s) or Representative Signature of client(s) or Representative and date signed.

INFORMED CONSENT

Welcome to Kaleo Counseling Services, LLC. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you and your therapist. Any questions can be discussed when you sign them or at any time in the future.

COUNSELING SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things discussed outside of sessions.

The first 1-3 sessions will involve a comprehensive evaluation of your needs by your therapist. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work together might include. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about procedures, please discuss them whenever they arise. If your doubts persist, your therapist will be happy to discuss referring you to another mental health professional.

APPOINTMENTS AND PROFESSIONAL FEES

Appointments are usually 50 minutes in duration; upon therapist discretion, appointments can go to 60 minutes. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, please provide a 24-hour notice. If you miss a session without cancelling, or cancel with less than a 24-hour notice, you will be responsible for paying the hourly fee for the missed session. This fee will be waived only in situations of illness, emergency, or inclement weather. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be financially responsible. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Rates for service are maintained by each therapist (LPC, PLPC & CIT) and may vary depending on the type of therapy, expected modality and if any appropriate specialty protocols are expected to be utilized for which the therapist has been additionally certified to perform above and beyond their state licensure or academic title. It will be yours and your therapist's responsibility to establish the expected rate prior to or at the beginning of your initial appointment. Payment can be made by check, cash, credit card, HSA card, debit card or supported money transfer apps. However, the Counseling Intern rate is set by Kaleo at $10 per session and cash is appreciated. In the case of payment options that charge an additional fee outside of Kaleo's control the therapist may add a processing fee to the agreed upon rate to cover said fees and you will be informed prior to the payment processing transaction. All fees are due at time of service unless other arrangements have been agreed upon by all parties.

PROFESSIONAL RECORDS

Your therapist is required to keep appropriate records of the psychological services that are provided. Your records are maintained in a secure location in the office. Brief records are kept noting that you were present for your appointment, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that if you desire to see your records, initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

Kaleo Counseling Services, LLC policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. By signing this form, you are agreeing that you have read that document and have discussed any questions or concerns with your therapist. Please remember that you may reopen the conversation at any time during your work with your therapist.

CONTACTING YOUR THERAPIST

Messages can be left for your therapist on his/her confidential voice mail. Your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If for any number of unforeseen reasons, you do not hear from your therapist and you feel unable to keep yourself safe, go to your local hospital Emergency Room, or call 911. Your therapist will make every attempt to inform you in advance of planned absences and will provide you with the name and phone number of the therapist covering for him/her.

OTHER RIGHTS

If you are unhappy at any time with what is happening in therapy, please talk with your therapist so that your concerns can be heard. Such comments will be taken seriously and handled with care and respect. You may also request that you be referred to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your therapist's training and professional experience.

CONSENT TO THERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Signature of client(s) or Representative	Signature of client(s) or Representative
Date	Printed Name(s) of Client(s) or Representative

Kaleo Counseling Services

5498 St. Charles St. **636-447-0100** **8050 Watson Rd. Ste 335**
Cottleville, MO 63304 **St. Louis, Mo 63119**

Spouse #1 Demographic Information: Today's Date:

Name:

Date of Birth: Relationship Status:

Address:

Spouses Name: Years Married:

Names & ages of Children:

Home/Mobile Phone: Can we leave a message at this number? Y / N

Email: Is it ok to email you?: Y / N

Occupational status: (FT, PT, Student, Stay-at-home Parent etc):

Current Employer: Position/Title

Emergency Contact: Relationship: Phone:

Current Concerns:

Briefly describe concerns and goals you have for counseling:

If you have received counseling or any prior professional services, please give dates & results:

Do you feel safe in your current living environment: Y / N

Behavior –Circle any of the following behaviors that apply to you:

Withdrawal	Cutting	Low motivation	Panic attacks	Difficulty Keeping Job
Insomnia	Take Drugs	Eating Problems	Crying/tearful	Suicide Attempts
Work too hard	Compulsions	Drink in excess	procrastination	Concentration problems
Phobias	Risk Taking	Aggressive behavior	temper outbursts	impulsive reactions

Others:

Thoughts – please answer questions below:

Do you currently have suicidal thought or thoughts of death/wanting to die? Y / N In the past? Y / N

Do you currently have thoughts of physically hurting or harming someone else? Y / N In the past? Y / N

Feelings – Circle any of the following feelings that apply to you:

Angry	Hopeless	Depressed	Regretful	Bored	Guilty	Conflicted
Anxious	Excited	Envious	Elated	Restless	Contented	Intense grief
Tense	Lonely	Panicky	Fearful	Energetic	Judged	Ashamed
Jealous	Helpless	Sad	Other:_____			

Medical Conditions: Sometimes medical conditions can greatly affect our mental and emotional health. Please let us know of any medical conditions you have been diagnosed with: (hypo/hyperthyroid, high blood pressure, seizures, hormone issues, anemia, chronic conditions, asthma, migraines, arthritis, learning disabilities etc.).

_____

_____

Mental Health: Please place a checkmark next to any conditions that have been diagnosed by a doctor or mental health professional for you or an immediate member of your family. If a family member, please indicate your relationship to the person affected.

_____ADD/ADHD_____ _____Depression_____

_____Generalized Anxiety Disorder_____ _____Schizophrenia_____

_____Borderline Personality Disorder_____ _____Bipolar Disorder_____

_____Alcoholism/Drug Abuse_____

_____Other_____

Medications: Medications and supplements often have side effects or directly effect emotional and mental health. Please let us know any medications or natural supplements/vitamins you are currently taking.

Kaleo Counseling Services

5498 St. Charles St. **636-447-0100** **8050 Watson Rd. Ste 335**
Cottleville, MO 63304 **St. Louis, Mo 63119**

Spouse #2 Demographic Information: Today's Date:

Name:

Date of Birth: Relationship Status:

Address:

Spouses Name: Years Married:

Names & ages of Children:

Home/Mobile Phone: Can we leave a message at this number? Y / N

Email: Is it ok to email you?: Y / N

Occupational status: (FT, PT, Student, Stay-at-home Parent etc):

Current Employer: Position/Title

Emergency Contact: Relationship: Phone:

Current Concerns:

Briefly describe concerns and goals you have for counseling:

If you have received counseling or any prior professional services, please give dates & results:

Do you feel safe in your current living environment: Y / N

Behavior –Circle any of the following behaviors that apply to you:

Withdrawal	Cutting	Low motivation	Panic attacks	Difficulty Keeping Job
Insomnia	Take Drugs	Eating Problems	Crying/tearful	Suicide Attempts
Work too hard	Compulsions	Drink in excess	procrastination	Concentration problems
Phobias	Risk Taking	Aggressive behavior	temper outbursts	impulsive reactions

Others:

Thoughts – please answer questions below:

Do you currently have suicidal thought or thoughts of death/wanting to die? Y / N In the past? Y / N

Do you currently have thoughts of physically hurting or harming someone else? Y / N In the past? Y / N

Feelings – Circle any of the following feelings that apply to you:

Angry	Hopeless	Depressed	Regretful	Bored	Guilty	Conflicted
Anxious	Excited	Envious	Elated	Restless	Contented	Intense grief
Tense	Lonely	Panicky	Fearful	Energetic	Judged	Ashamed
Jealous	Helpless	Sad	Other:_____			

Medical Conditions: Sometimes medical conditions can greatly affect our mental and emotional health. Please let us know of any medical conditions you have been diagnosed with: (hypo/hyperthyroid, high blood pressure, seizures, hormone issues, anemia, chronic conditions, asthma, migraines, arthritis, learning disabilities etc.).

_____

_____

Mental Health: Please place a checkmark next to any conditions that have been diagnosed by a doctor or mental health professional for you or an immediate member of your family. If a family member, please indicate your relationship to the person affected.

_____ADD/ADHD_____ _____Depression_____

_____Generalized Anxiety Disorder_____ _____Schizophrenia_____

_____Borderline Personality Disorder_____ _____Bipolar Disorder_____

_____Alcoholism/Drug Abuse_____

_____Other_____

Medications: Medications and supplements often have side effects or directly effect emotional and mental health. Please let us know any medications or natural supplements/vitamins you are currently taking.

HIPAA NOTICE AND PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Protecting your confidential health information is important to us.

As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations we are required to ensure you are aware of our privacy policies and legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration of our operation and must be followed by our office. This notice will be in effect until it is replaced; it became effective 01/01/06.

This Notice describes your rights as our client or your child's rights as our client and our obligations regarding the use and disclosure of your Protected Health Information (PHI) and your child's PHI. We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all PHI that we maintain, including PHI we created or received before the changes were made. Changing this notice will precede all significant modifications. Copies of this notice are available at your request. We will post a copy of the current notice in the waiting area.

Each time you visit Kaleo Counseling Services, LLC, a record of your visit is made. This record typically contains information regarding symptoms, observations, assessments (including test results and diagnoses), plans for future treatment, and billing information.

We will use and communicate your PHI for the following purposes only:

I. Protected Health Information Uses and Disclosures for Treatment, Payment, and Health Care Operations

Information regarding your protected health information (PHI) may be used and disclosed for the purpose of treatment, payment, and other health care options. Examples cited below further explain the use and disclosure process.

Treatment: We may use and disclose your PHI or your child's PHI to provide you with the best treatment and services possible. This may include administrative and clinical office procedures within our office and in coordination with other service providers, such as in clinical supervision or in case consultation with law enforcement and child protective services.

Obtaining Payment: We may use and disclose your PHI or your child's PHI so that the treatment and services you receive at our office may be billed to, and payment may be collected from you, an insurance company, or another party.

Health Care Operations: We may use and disclose your protected healthcare information in relations with our health care process. These processes include quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management, supervision and care coordination. We may use your PHI to assist you with appointment reminders in the form of voicemail messages or letters.

II. Uses and Disclosures Requiring Authorization

At any time you may provide in writing, your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation. You may not revoke an authorization to the extent that (1) Kaleo Counseling Services, LLC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Each of the uses and disclosures listed immediately below requires your written permission.

a. Payment. We will ask for your written permission to use and disclose information regarding the services provided to you in order to bill and collect payment from you.

b. Other Uses and Disclosures. In addition to the above, we will require your written permission for us to use or disclose your medical information:

- If Kaleo Counseling Services, LLC refers you to another health care provider (such as a physician). We will ask you to authorize our sending your health information to them so that they have the information needed to diagnose or treat you.
- If you ask Kaleo Counseling Services, LLC to disclose your health information to anyone, including other health care or educational professionals.
- To friends or family members who are involved in your care. If your written permission is not obtained and you are not present and able to agree or object, such communications shall be made only by authorized healthcare providers when, in their professional judgment, such disclosure is needed to help ensure your safety or the safety of others.

Any uses or disclosures of your medical information that are not specifically covered by this Notice of Privacy Practices or by the laws that apply to us will be made only with your written permission. Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice

III. Uses and Disclosures Requiring Neither Consent nor Authorization
Kaleo Counseling Services, LLC may use or disclose PHI without your consent or authorization in the following circumstances:
Child Abuse – If Kaleo Counseling Services, LLC has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if Kaleo Counseling Services, LLC observes a child being subjected to conditions that would reasonably result in abuse or neglect, Kaleo Counseling Services, LLC must immediately report such information to the Missouri Children's Division. Kaleo Counseling Services, LLC must also report suspected sexual abuse or molestation of a child under 18 years of age to the Children's Division. Kaleo Counseling Services, LLC may also report child abuse or neglect to a law enforcement agency or juvenile office.
Adult and Domestic Abuse – If Kaleo Counseling Services, LLC has reasonable cause to suspect that an eligible adult (defined below) presents a likelihood of suffering physical harm or is in need of protective services, Kaleo Counseling Services, LLC must report such information to the Missouri Department of Social Services. "Eligible adult" means any person 60 years of age or older, or an adult with a handicap (substantially limiting mental or physical impairment) between the ages of 18 and 59 who is unable to protect his or her own interests or adequately perform or obtain services which are necessary to meet his or her essential human needs.
Health Oversight Activities: The Missouri Attorney General's Office may subpoena records from Kaleo Counseling Services, LLC relevant to disciplinary proceedings and investigations conducted by the State of Missouri Committee for Professional Counselors and the State of Missouri Committee for Social Workers.
Law Enforcement: We may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and Kaleo Counseling Services, LLC will not release information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. Kaleo Counseling Services, LLC will make all reasonable efforts to inform you in advance if this is the case.
Serious Threat to Health or Safety – When Kaleo Counseling Services, LLC judges that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted to you or your child or by you or your child on yourself or another person, Kaleo Counseling Services, LLC must disclose your relevant confidential information to the appropriate professional workers, public authorities, the potential victim, his or her family, or your family.
Workers' Compensation – If you file a worker's compensation claim, Kaleo Counseling Services, LLC must permit your record to be copied by the Missouri Labor and Industrial Commission or the Division of Worker's Compensation of the Missouri Department of Labor and Industrial Relations, your employer, you and any other party to the proceedings.
Your Authorization: Other than as stated above or where Federal, State or Local law requires us, we will not disclose your PHI other than with your written authorization. You may revoke this authorization in writing at any time.
IV. Your rights regarding your PHI or your child's PHI
Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, Kaleo Counseling Services, LLC is not required to agree to a restriction you request.
Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen by Kaleo Counseling Services, LLC. On your request, we will send your bills to another address.). You have the right to ask Kaleo Counseling Services, LLC to communicate with you in a certain way or at certain locations. We will accommodate all reasonable requests. Unless we are otherwise instructed, phone calls to you from Kaleo Counseling Services, LLC for purposes of scheduling or canceling sessions and mailings to you for purposes of billing will be directed to the home phone number(s) and home address that you provide us. Requests for alternative modes or locations of communication must be submitted in writing.
Right to Inspect and Copy – You have the right to read, review and copy your PHI such as treatment and billing records that we keep and use to make decisions about your care for as long as the PHI is maintained in the record. You must submit a written request to Kaleo Counseling Services, LLC in order to inspect and/or copy records of your PHI. We may deny your access to PHI under certain limited circumstances, but in some cases, you may have this decision reviewed. On your request, Kaleo Counseling Services, LLC will discuss with you the details of the request and denial process. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.
Right to Amend: If you believe the PHI we have about you or your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To make this amendment you

must submit your request in writing to Kaleo Counseling Services, LLC. You must also provide a reason for the request. We may deny your request in certain cases.

Right to an Accounting of Disclosures – You have the right to receive an accounting of disclosures of PHI. This is a list of the disclosures we made of medical information about you to others except for purposes of treatment, payment and operations identified above, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. To obtain this list, you must submit your request in writing to Kaleo Counseling Services, LLC. It must state a time period, which may not be longer than ten years and may not include dates before January 1, 2006. Your request should indicate in what form you want the list. The first list you request in a 12-month period will be free, but we may charge you for the costs of providing additional lists. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

We reserve the right to change this notice and to make the revised or changed notice effective for health information we already have about you or your child as well as any information we receive in the future. We will post the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision Kaleo Counseling Services, LLC makes about access to your records, or have other concerns about your privacy rights, you may contact the Missouri Department of Health, Bureau of Health Facility Regulation at 1-573- 751-6303 and/or the State Attorney Generals Office, Consumer Hotline, 1-800-392-8222 for additional assistance. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Kaleo Counseling Services, LLC will not retaliate against you for exercising your right to file a complaint.