



Thank you for choosing Connections Family Therapy! Please complete the forms below. If the paperwork is not completed before the first session, you will be asked to stay after the intake session to complete the paperwork. This information is very helpful to have prior to beginning the first session. You will also be asked to show a photo ID and a copy of your insurance card, so please have these with you.

My office is located at 1930 St. Andrews Court NE, Suite T, Cedar Rapids. Turn off of Blairs Ferry Road at the sign for St. Andrews golf course. Once you enter the parking lot area, you will see 2 buildings that look very similar. I am in the building on the left that has the address 1930 on it. Enter the building on the east/right side. There is a St. Andrews crest near the door. Enter through that door and walk down the hall until you come to the end where you will find a waiting room. Have a seat and send me a text that says, "here" and I will come and get you at your appointment time.

You are responsible for contacting your insurance provider to obtain benefit information prior to the first appointment. If pre-certification is required by your insurance, you must obtain this prior to the session.

Thank you!

Keri

Office Policies and Agreement for Services

Therapy Services:

I use a diverse mixture of different types of therapy theories in session, however, therapy will be goal-directed and problem-focused. This means that a treatment goal(s) is established following a thorough assessment. The client will take an active role in therapy. Commitment to therapy is essential for the most successful outcome. You may request a referral for a different therapy at any time, however, you must first pay all outstanding bills. Please inform me of any concerns you have regarding your therapy, so we can attempt to resolve these together.

_____ (initials)

Confidentiality:

Therapy is a place where you should feel safe and comfortable discussing difficult issues. The State of Iowa laws require that the majority of what is said in therapy be held in confidentiality. Parents do have the right to know the general content of therapy sessions for their minor children. Releases of Information will be used to give permission to communicate with other care providers, family members or friends as agreed upon by the client and their guardian if a minor.

Authorization to Release Information is NOT required in the following circumstances.

- 1) The client presents as a danger to themselves or someone else.
- 2) Child-abuse or Dependent adult abuse is **suspected**.
- 3) Billing purposes.
- 4) A court-ordered subpoena is presented.

_____ (initials)

Appointments:

A scheduled appointment is a contract between you and your therapist. In order for therapy to gain the highest level of effectiveness, appointments should be kept. If you are absolutely unable to keep your appointment, please give a 24 hour notice. Also, if you must cancel, it is best to reschedule promptly to get back into the therapist's schedule. Initialing this section grants the therapist permission to send a text message reminder for your scheduled appointment. Providing your e-mail address gives the therapist permission to communicate through e-mail.

Unless restricted by a third party payer, you may be billed for missed appointments. There is a \$50 charge for cancelled appointments without a 24 hour notice. If there are a continuation of missed appointments, therapy may be referred to another therapy source. If you are billed a no-show charge, please pay before your next scheduled appointment.

_____ (initials)

Emergency Access:

I am not able to handle emergency calls at this time. Please contact either the Abbe Center: 319-398-3562 or Foundation 2: 319-362-2174. If you are suicidal, please go to the emergency room at your nearest hospital (St. Luke's if under the age of 18).

_____ (initials)

Insurance Coverage and Fees:

- 1) Payment for services is your responsibility. Only your primary insurance will be billed (except for Medicare/Medicaid). It is your responsibility to obtain prior authorization for treatment and pay co-pays.
- 2) **Co-payments are expected at the time of service.**
- 3) The person who seeks therapy, either for himself/herself or for a minor, is responsible for payment. Parents are responsible for account payments for their minor child. Accounts unpaid after 90 days are subject to be released to collections. Clients will be billed for additional costs involved and a service charge of \$20 will be added to their account if their account is released to collection.
- 4) If no session has been scheduled for 60 days, I will understand that our therapeutic relationship has ended, unless otherwise agreed upon. If you want to continue counseling after that time, all outstanding bills will need to be paid before your file may be re-opened.

Fees:

Intake Interview –	\$185
Individual Therapy Session- 30 minute	\$95
Individual Therapy Session – 45 minute	\$115
Individual Therapy Session – 60 minute	\$150
Family Therapy Session –	\$150
Returned Check fee –	\$25 per incident

you may be charged for email or phone consultations, as well as completion of paperwork that requires more than 15 minutes of work per consultation. **\$50/30 minutes

Court-related Activities - (2 hr. min.)	\$300 per hour for depositions
	\$115 per hour travel time

_____ (initials)

Consent for Treatment:

I authorize and request my practitioner to carry out psychological treatment during the course of my treatment. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. I understand that therapy has both benefits and risks. Benefits include improvement in existing and new relationships, conflict resolution and identifying skills to deal with stressors. Possible risks include painful emotions arising from the discussion of difficult subjects as well as changes which could occur in relationships. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I understand that if I am seeking therapy for my child that I am the legal guardian or legal representative and that the policies described in this statement apply to the patient that I represent.

_____ (initials)

I have read the policy statement and agree to the terms.

Client/Guardian Signature

Date

Printed Name

Practitioner/Witness Signature

Date

Informed Consent Form for Treatment

Acknowledgment and Authorization Form (#1): I hereby acknowledge that I was given the opportunity to read and to receive a copy of the Notice of Privacy Practices for Connections Family Therapy, LLC.

Authorization to Release Information to Insurance Carrier (#2): I hereby authorize Connections Family Therapy, LLC to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, prognosis, progress, and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Connections Family Therapy, LLC.

I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

This authorization shall continue in force and effect until revoked in writing by me.

Authorization to Pay Supplier (#3): I hereby authorize payment of Medical Benefits and/or Mental Health Benefits to Connections Family Therapy, LLC for services rendered.

Authorization for Treatment (#4): I give Connections Family Therapy, LLC and Keri L Christensen, LISW consent to treat myself or my minor child.

Authorization for Collection (#5): I understand that if I fail to pay, the account can be turned over for collection and that I will be responsible for all costs involved.

I acknowledge and agree to the authorizations listed above (#1, 2, 3, 4, & 5).

Client / Insured Signature / Biological Parent or Legal Guardian

Date

Client

Name: Last _____ First _____ M.I. _____
Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell: (____) _____
SSN: _____ Gender: M or F Birth Date: _____
Employer: _____ Address: _____
Work Phone: (____) _____

Spouse

Name: Last _____ First _____ M.I. _____
Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell: (____) _____
SSN: _____ Gender: M or F Birth Date: _____
Employer: _____ Address: _____
Work Phone: (____) _____

When the client is a minor, please fill in the Mother's & Father's information.

Mother

Name: Last _____ First _____ M.I. _____
Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell: (____) _____
SSN: _____ Birth Date: _____
Employer: _____ Address: _____
Work Phone: (____) _____

Father

Name: Last _____ First _____ M.I. _____
Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell: (____) _____
SSN: _____ Birth Date: _____
Employer: _____ Address: _____
Work Phone: (____) _____

Emergency Contact (not spouse or parent)

Name: _____ Relationship: _____
Address: _____ Phone: _____

Send Statement to and Responsible Party for Payment:

Name: _____ Relationship: _____
Address: _____ City: _____
Phone: _____ Zip: _____

Insurance:

Company: _____ Policy ID#: _____
Insured's name: _____ Group #: _____
Authorization #: _____ Number of Sessions: _____
Dates of Authorization: From _____ to _____ Deductible: _____ Co-Pays: _____

I affirm that the above information is true: Signed _____ date: _____

Medical and Social History Form

Client Name: _____ Date: _____
Address: _____
DOB: _____ Age: _____ Race: _____
Referral Source: _____

FAMILY INFORMATION:

FAMILY OF ORIGIN:

Parents names, ages, and marital status: _____
Names and ages of siblings: _____
Describe your family life as you grew up: _____

CURRENT LIVING SITUATION:

Marital Status: [] Never married [] Cohabiting [] Married [] Separated [] Divorced [] Widowed
If not living alone, with whom are you now living? _____

If Married : Spouse's Name: _____ DOB: _____ Date of Marriage: _____
If this is not your first marriage, note the dates of previous marriage(s) and the name(s) of your previous spouse(s): _____
Is your relationship satisfactory, why or why not? _____

Names and ages of children: _____
Do you have special concerns regarding any of your children? If so, explain: _____

PERSONAL INFORMATION:

Educational level achieved: Self _____ Spouse: _____
If currently a student, list name of the school and full or part-time status: _____

What is your current job: _____
What other types of work have you done: _____

Religion: Self: _____ Spouse: _____

HEALTH INFORMATION:

What is your current reason for seeking counseling? _____

Have you previously sought counseling? If so, who did you see, why and when? _____

Was counseling satisfactory? Why or why not? _____

Physician: _____ Clinic: _____

Do you have any major medical concerns? If so, describe: _____

Have you ever had a major head injury? _____

Do you ever lose control of your anger? If so, explain: _____

Have you or a family member ever been hospitalized for emotional problems? If so, explain when, where, & why: _____

Are you currently taking any medications? If so, what and what dosage? _____

Do you have any known allergies? If so, specify: _____

ALCOHOL AND DRUG USE:

Have you ever felt that you should cut down on your drinking? _____

Have people annoyed you by criticizing your drinking? _____

Have you ever felt bad or guilty about your drinking? _____

Have you ever had a drink early in the morning to steady your nerves or get rid of a hangover? _____

How much alcohol do you consume in a week, typically? _____

Have you ever used any illegal drugs? If so, which ones and how often? _____

Has drinking or drug use caused you problems with the law or at work? If so, explain: _____

Have you ever sought treatment for substance abuse? If so, describe when and where and what effect it has on your use? _____

Has anyone in your family had problems with substance use or treatment for substance use? If so, explain: _____