Kristina Fiske Counseling LLC, LPC

In Practice at Georgia Psychology and Counseling

Office Phone (706) 364-4599
Fax (706) 364-4589

211 Pleasant Home Road Suite G1
Augusta GA 30907

Please note that all participants in therapy that are 18 years and older must fill out their own individual packet

Date: _____ Client's name: _____ Gender: M F

Ethnicity: _____ DOB: _____ Age: _____ SSN: _____

Place of Employment: _____ Job Title: _____

(If Applicable): School: _____ Grade: _____

For children/adolescent clients under 18, please provide the following information:

Parent/Guardian's name (if applicable): _____ Relationship to client: _____
Parent/Guardian's Date of Birth (if applicable): _____
Parent/Guardian's Phone Number (In case of emergencies): _____
If parents not married/together what is the custody agreement? Sole Joint Other:_____
(Please provide paperwork to prove legal custody)
Who has legal decision-making power for medical/psychological treatment? _____

Contact Information

Client's phone numbers: Home_____ Mobile _____ Other_____

Client's Address: _____ City_____ State _____ Zip_____

Client/Guardian's email address: _____

Insurance Information (please write information along with providing copy of card)

Insurance Plan Name: _____ Policy number: _____

Group Number: _____ Insurance phone numbers (claims/benefits): _____

Subscriber's name: _____ Relationship to client: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Mental Health History

Has client ever had psychological testing? Yes No **Approximate dates: _____**
Has client ever had counseling/therapy? Yes No **Approximate dates: _____**
Has client been evaluated by a psychiatrist? Yes No **Approximate dates: _____**
Current medications for psychological conditions: _____
Have you or a family member previously been a client? Yes No **If so, when?**
_____

Briefly explain reason for seeking out services: _____
_____
_____

Professional Disclosure Statement
Informed Consent

Welcome to the office of Kristina Fiske, LPC. I am very pleased that you selected my practice for your care, and I sincerely look forward to assisting you. This document is designed to inform you about what you can expect from therapy with Kristina, policies regarding confidentiality and emergencies, and several other details regarding your treatment here. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with Kristina is a collaborative one, and she welcomes any questions, comments, or suggestions regarding your course of care at any time.

Confidentiality and Informed Consent with Insurance Usage

All information that you provide during a session is confidential, with the following exceptions: (1) you direct Kristina to tell someone else and you sign a "Release of Information" form; (2) Kristina determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; (4) information released for billing purposes to your insurance, EAP, or managed care company, or (5) Kristina is ordered by a judge to disclose information. In the latter case, Kristina's license does provide her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right. However, she will comply with a judge's order if failing to do so would result in her being held in contempt. The release of records or information related to a couples or family session requires the consent of all the adults who participated.

Litigation Limitation

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

In Case of an Emergency or Crisis

Georgia Psychology and Counseling is considered to be an outpatient practice, and we are set up to accommodate individuals who are reasonably safe and resourceful. Kristina is not available at all times. If at any time this does not feel like sufficient support, please inform Kristina, and she can discuss additional resources. It could be that you need to schedule more frequent visits or be referred to a facility with a more intensive treatment option. Generally, Kristina will return phone calls within 24-48 hours. If you have a true mental health emergency in which there is a question of imminent risk of harm, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Lighthouse Care Center of Augusta for clients under 21: 706-651-0005
- Call Doctor's Hospital at (706) 651-3232
- Call 911 or Go to your nearest emergency room.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with Kristina remains therapeutic and professional. Therefore, we've developed the following policies:

Video Monitoring and Recording: All of the offices here at Georgia Psychology and Counseling are video monitored and recorded for safety and liability purposes.

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Kristina may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with her. Out of respect for yourself and the therapeutic process, Kristina does ask that all clients silence their phones and do their best not to respond to messages or take calls during therapy.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. Emails and texts should not be used for crisis situations or as a substitute for therapy. We ask that emails and texts only be used for brief matters of communications that can allow for a 24-48 hour response time. You also need to know that we are required to keep a copy of all emails and other electronic communications as part of your clinical record. If you find the need to communicate frequently with Kristina between sessions, it may be that you need to schedule more frequent visits. You are encouraged to protect your own confidentiality by controlling access to your communications with Kristina such as by using passwords only known by you, controlling access to your computer, etc. Please discuss with Kristina the preferred way for communicating outside of session.

Facebook, LinkedIn, Instagram, Pinterest Etc.: It is Kristina's policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. For that same reason, we ask all clients not to communicate with Kristina via any social networking website.

Search Engines such as Google, etc.: It is Kristina's policy not to search for her clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to Kristina as you feel appropriate. If there is content on the Internet that you would like to share with Kristina for therapeutic reasons, please print this material out and bring it to your session.

Telemental health sessions: Kristina offers phone sessions and video sessions as needed.

In summary, technology is constantly changing, and there are implications to all of the above that Kristina may not realize at this time. Please feel free to ask questions, and know that she is open to any feelings or thoughts you have about these and other modalities of communication.

For Parents/Guardians of Minors

It is our policy that any minor not be left unattended even during their session. By signing this policy and disclosure you agree not to leave your child in the office or while your child is being seen in session. If your child is of driving age and they will be driving themselves to and from appointments then they do not need to have an adult present at their sessions; however, Kristina does prefer a parent is present for at least the initial session to discuss any concerns they may have. Please discuss this with Kristina if you have any questions.

- ☐ I consent to allowing my child to drive themselves to their appointments
- ☐ I do not consent to allowing my child to drive themselves to their appointments

Fees and Insurance

Please make yourself acquainted with Kristina's fee schedule and cancellation policy. If there are questions or concerns please make her aware before your session begins. Insurance policies are a contractual agreement between you, the subscriber, and your insurance company. We are happy to assist you as needed and will bill charges on your behalf. However, understand that you will ultimately be responsible for payment of coinsurance and deductibles as well as fees for any non-covered services, due upon denial of insurance coverage. If you do not provide your insurance information within 8 hours of your session, you will be charged the standard self-pay rate prior to your session, which can be adjusted for future sessions once insurance co-pay information has been obtained.

Payments

Our policy is to request payment for all services immediately following or preceding each session. Exceptions need to be agreed to in advance. All services provided will be charged directly to you, with the exception of those clients who have insurance or employee assistance program. In that case, your insurance company or EAP will be billed, and you will be asked to pay any coinsurance, and deductible amounts at the time service is rendered. Each individual is ultimately responsible for payment. We will make every effort to secure payment through your insurance, but in the event that we do not receive payment as expected from them, your credit card on file will be charged as soon as your insurance company notifies us of partial or non- payment, as you will be responsible for payment. This is why a credit card must be left on file; if full funds are not available, you will be billed. Receipts available upon request. For services, we accept cash, check, and most major credit cards. There is a $35.00 fee for those checks that are returned for insufficient funds. Please make note of this.

Cancellation Policy

Because we set aside your appointment time exclusively for you, we ask that you please give a minimum of **24 hours notice** if you need to cancel or change your appointment. Appointments not cancelled with at least 24 hours notice will result in a $60 cancellation/no show fee charged at the time of your scheduled appointment. Emergencies will be considered, and Kristina asks that you notify her of these as soon as possible to allow her an opportunity to offer your appointment to someone else. It should also be noted that if appointments become rescheduled/cancelled frequently or if you miss 2 appointments back to back that Kristina will cancel all future appointments and may refer you to another provider. This is out of consideration for both Kristina's time as well as other clients who may prefer to come in during your time slot. **Please CALL Georgia Psychology and Counseling at (706) 364-4599 if you need to cancel or reschedule.** If you call be sure to leave a message.

Please sign below to indicate that you have received and read the "Professional Disclosure Statement", and agree to comply with the policies, including the 24 hour cancellation charge/no show fee, indicated.

_____ _____

Signature of client or parent/guardian Date

If using insurance/EAP

I understand and agree that information regarding my treatment and care may be released to my insurance/EAP company for the purpose of securing reimbursement for services rendered and continuation of therapy. This may include periodic audits of my records by the insurance company or the behavioral contract organization.

_____ _____

Signature of client or parent/guardian Date

Kristina Fiske Counseling LLC, LPC

In Practice at Georgia Psychology and Counseling

Office Phone (706) 364-4599
Fax (706) 364-4589

211 Pleasant Home Road Suite G1
Augusta GA 30907

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Signature: _____

Relationship to Patient (If applicable): _____

Kristina Fiske Counseling LLC, LPC

In Practice at Georgia Psychology and Counseling

Office Phone (706) 364-4599
Fax (706) 364-4589

211 Pleasant Home Road Suite G1
Augusta GA 30907

Credit Card Guaranty of Payment

I understand that Georgia Psychology and Counseling/Kristina Fiske will be billing my insurance company for therapy, evaluation services and psychological testing, or any other covered services. I also understand that Georgia Psychology and Counseling is billing my insurance company as a courtesy to me rather than my paying for services upfront and waiting to be reimbursed by my insurance company. I further understand that I am responsible for all reasonable and customary fees that my insurance company does not pay such as deductibles, co-pays, co-insurances, as well as late cancellations or no show charges ($60). I understand that my provider will work with me and my insurance company to receive payment from them. For my convenience they will wait a reasonable amount of time to be reimbursed by my insurance carrier for services delivered. However, sometimes insurance companies do not pay in a timely manner and sometimes they do not reimburse at the rate that was initially expected and I will be responsible for the difference indicated by the insurance company. I understand that fees are due at the beginning of services and must be paid in full unless a payment plan has been agreed to by my provider.

I hereby acknowledge that I understand and give Georgia Psychology and Counseling/Kristina Fiske permission to charge my credit card for any services that have not been paid by myself or my insurance carrier. I understand that this form is valid for three years unless I cancel the authorization in writing. If I cannot provide a credit card to place on file then I agree to allow Georgia Psychology and Counseling/Kristina Fiske to release my demographic information to a collection agency for reimbursement if payment or balance has been outstanding for a minimum of 120 days.

If your child is driving themselves, this will be the card charged unless otherwise noted.

CREDIT CARD MUST BE LEFT ON FILE UNLESS OTHERWISE DISCUSSED.

Patient Name

Cardholder Name (if different from the patient)

Cardholder Billing Address

Type of Credit Card (Visa, MasterCard, Discover, Amex)

Credit Card Number Expiration Date

Signature and Date

Kristina Fiske Counseling LLC, LPC

In Practice at Georgia Psychology and Counseling

Office Phone (706) 364-4599
Fax (706) 364-4589

211 Pleasant Home Road Suite G1
Augusta GA 30907

Statement of Patients' Rights

Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Patients' Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Patient Signature Date
(Parent/ Guardian sign if patient is under 18 years old)

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature Date

Kristina Fiske Counseling LLC, LPC

In Practice at Georgia Psychology and Counseling

Office Phone (706) 364-4599
Fax (706) 364-4589

211 Pleasant Home Road Suite G1
Augusta GA 30907

Two-Way Records Release

Complete this form only if you would like me to communicate with another facility or person.

Date: _____ **Client's name:** _____ **Gender:** M F

Ethnicity: _____ **DOB:** _____ **Age:** _____ **SSN:** _____

Parent/Guardian's name (if applicable): _____ **Relationship to client:** _____

Parent/Guardian's name (if applicable): _____ **Relationship to client:** _____

If there is a custody agreement: Shared Sole Joint Other: _____

Who has legal decision-making power for medical/psychological treatment? _____

Signature of legal decision-maker for treatment: _____

Patient's phone number: _____**Address:** _____

I authorize a two-way release of records/information between the following individuals/facilities:

☐ **Kristina Fiske Counseling LLC** **AND**

Facility/Person: _____
Phone: _____
Fax: _____

Type: Entire record Attendance
Insurance info Evaluation Results
Other _____

Valid for: 3 months 6 months 1 year

☐ **Kristina Fiske Counseling LLC** **AND**

Facility/Person: _____
Phone: _____
Fax: _____

Type: Entire record Attendance
Insurance info Evaluation Results
Session notes Other _____

Valid for: 3 months 6 months 1 year

Please draw a line through unused sections above.

Kristina Fiske Counseling LLC, LPC

In Practice at Georgia Psychology and Counseling

Office Phone (706) 364-4599
Fax (706) 364-4589

211 Pleasant Home Road Suite G1
Augusta GA 30907

How did you hear about Kristina?

___ My insurance company website
___ My insurance company call center
___ Google or other search engine
___ Psychologytoday.com
___ Alltherapist.com
___ Networktherapy.com
___ Healthgrades.com
___ Apa.org
___ Another website: _____

___ A doctor referred me: Dr. _____
___ A mental health facility: _____
___ A lawyer referred me _____

___ A flyer
___ A magazine
___ A newspaper

___ A family member referred me
___ A friend referred me
___ A coworker referred me
___ My employer/ place of business referred me
___ Other Please describe: _____