Restoration Christian Counseling

Patient Information Form

Patient Data

Last Name _____ First Name _____ Middle Initial __

Mailing Address

Street _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Please circle: Okay to text? Yes No Gender: Male Female

Social Security Number: _____

Birthdate _____ Age _____ Today's Date _____

Payment Information

☐ Self-Pay
Name of Responsible Party _____

☐ Insurance – Guarantor _____
Social Security Number _____
Relationship to Patient:
- ☐ Self
- ☐ Other _____

Insurance Company Name _____

Emergency Contact

Name _____

Home Phone _____ Cell Phone _____

Signatures

Name of Insured _____

Spouse or Guardian's Signature _____

Restoration Christian Counseling

Payment Authorization/Release of Information

Client Name _____

Social Security Number _____ Date of Birth _____

☐ I authorize payment of my insurance to the provider named on my insurance claim form. I further authorize release of information required by any third-party payer regarding any claim made related to me. A copy of this form can be used in place of the original. **I understand that I am financially responsible for charges not paid by my insurance.**

Client's Signature _____ Today's Date _____

Witness Signature _____ Today's Date _____

Parent/Guardian Signature _____ Today's Date _____

Insurance Company Name _____

Member ID _____

RESTORATION
CHRISTIAN COUNSELING

Payment options

- Private health insurance
  - Restoration Christian Counseling accepts most health insurance policies and will work with you to predetermine benefits and coverage.
- Self-pay ability for those who may have no private insurance.
  - Part of our goal is to offer services to those who may not have insurance or mental health coverage. Restoration Christian Counseling is dedicated to making this payment option as manageable as possible in order to meet your budget needs.

Payment Requirements

- The fee for individual or family sessions 45 to 55 minutes in length is $80.00, unless otherwise indicated by therapist. You are responsible to pay for the first session out of pocket unless the therapist has already verified that your session will be covered by your insurance or another source. If you have insurance which covers these fees, then whatever portion has been covered by insurance will be returned to you. If you do not have insurance, you have not met your deductible, or you have a co-pay, all or the portion for which you are responsible, according to your insurance plan, will be applied to your bill.
- Accounts must be kept current in order to schedule follow up appointments.

Cancellation Policy

- Restoration Christian Counseling values your commitment to treatment. If you need to reschedule or cancel an appointment, we ask that you give us 24 hour notice. If you have to cancel or reschedule the same day as your appointment or you fail to show up for an appointment, you will be charged a $25.00 fee.

Emergency Policy

- Restoration Christian Counseling does not guarantee after-hours crisis intervention. If you begin having thoughts or concerns about hurting yourself, hurting someone else, or being hurt by someone else either go to your nearest emergency room or call 911.

Communication Policy

- We care about you and will provide therapeutic support throughout treatment. We cannot guarantee immediate or same day return of phone calls or text messages; however, we will try to return communication within 24 hours during business hours. Our regular business hours are Monday through Friday 8:00am to 3:00pm, Wednesday from 8:00am to 8:00pm, and every other Saturday morning from 8:00am to 12:00 noon.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date

RESTORATION
CHRISTIAN COUNSELING

Consent and Permission for Treatment

I acknowledge that **Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA** and will be providing mental health and Christian counseling, assessment and treatment services to me.

I acknowledge that it is the obligation of **Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA** to secure and protect my confidentiality with exceptions pertaining to certain laws requiring discovery of certain information.

I fully understand that there will be guarantee of product or result from these services and that individual experiences with such treatment vary.

Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA reserve the right and have a duty to report any and all abuse and neglect of any person or persons, adult, juvenile or other pertaining to violent or abusive offenses to appropriate authorities not excluding the local police and Child Protective Services.

Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA reserve the duty report any and all threats against any person or persons to the intended person(s) as well as police and local authorities.

Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA reserve the right to report any threats to do any manner of bodily harm made against oneself to the proper authorities.

Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA reserve the right to release any and all information to agencies, authorities and persons with a need to be informed if a client is in need of hospitalization. Should the client disclose any

personal information pertaining to the client's mental health, substance abuse or any information in court proceedings then confidentiality is waived by the client.

I fully understand all of the above statements of my confidentiality and about my personal mental health, substance abuse, conditions and treatment. I give my full consent to **Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA** to provide assessment and treatment services to me.

I fully understand that I am not contractually bound for any period of time to services of **Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA** and may revoke my participation of the services and treatment at any time.

Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA also reserves the right to not be contractually bound for any period of time to the client and may revoke services or treatment an any time without notice.

In signing this document, I give full permission to **Restoration Christian Counseling, PLLC, Cathleen Donahue LPCC, Lee Ann Hunt LCSW, Sarah Knisely LPCC, Stephen Applegate Certified Psychologist with Autonomous Functioning, Caren Gatlin LPCC, Maggie Osbourne LPCA, Christina Dillon LPCA** for assessment and treatment in accordance with faith-based practices and acknowledge that all counseling services will be based upon Christian biblical principles and beliefs.

If either Christina Dillon LPCA or Maggie Osbourne LPCA will be my clinician, I have been informed that she is a Licensed Professional Clinical Associate. I understand that my clinician will abide by all Licensed Professional Clinical Counseling Board legal and ethical standards. I also understand that my clinician, as mandated by the Kentucky LPCC Board, practices counseling while under supervision; therefore, knowing that my confidential information will be carefully protected, I agree to release information pertinent to my counseling treatment to the supervisor(s) of my clinician: Stephen Applegate Certified Psychologist with Autonomous Functioning, Cathleen Donahue LPCC, and/or Patrick Holley LPCC.

Client Name (print) _____

Client Signature _____

Parent/ Guardian Signature _____

Date _____

As the clinician, I have explained this form to the client(s) and answered any and all questions to the best of my ability. It is my professional judgment that this person(s) is capable of making, and has made, an informed decision to accept treatment and counseling services.

Restoration Christian Counseling Staff Signature _____

Date _____

Restoration
Christian Counseling
100 W. Oak St., Nicholasville, KY 40356

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site