Katie Freeman, MSW, LCSW
221 N. East Avenue, Suite 101
Fayetteville, AR 72701
Phone (479) 957-0189 Fax (479) 431-2548

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ Birth Date: _____

Address: _____ City/State: _____ Zip: _____

(Cell): _____ (Work): _____ (Home): _____

Social Security #: _____ Marital Status: _____

Spouse's Name: _____ Spouse's Occupation: _____

Referred by: _____

Name & Relationship of others living in the home: _____

_____

Have you ever been hospitalized? Yes No

If yes, please describe: _____

Are you currently taking any medication? Yes No

If yes, name of medication/dosage: _____

Has anyone in your family even been treated for a psychological problem? Yes No

If yes, please describe: _____

_____

Have you had any previous psychological treatment? Yes No

If yes, please describe: _____

Do you drink alcohol? Yes No

If yes, how much do you drink weekly? _____

Have you ever had a drug problem? Yes No

If yes, please describe: _____

Reason for visit: _____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

Please check any of the following changes that apply to you.

____ Sleep

____ Appetite

____ Energy Level

____ Concentration

____ Memory

____ Sadness

____ Irritability

____ Lack of enjoyment in usual activities

____ Hopelessness

____ Guilt

____ Elation

____ Increased Talking

____ Racing Heart

____ Difficulty Breathing

____ Sweats/chills

____ Numbness/tingling in fingers

____ Lightheadedness

____ Fears of dying or going crazy

____ Chest Discomfort

____ Excessive Worry

____ Compulsive Behavior

____ Racing Thoughts

____ Poor judgement

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INFORMED CONSENT TO TREAT

Welcome to my practice. Beginning therapy is an important decision, and I am glad I can be part of that experience for you. The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing and dating at the bottom of this document.

Benefits and Risks of Treatment

There are many benefits to psychotherapy. These benefits have been established by scientific research but are sometimes difficult to monitor or pinpoint. I am responsible for ensuring that, for the most part, the benefits of your therapy outweigh the risks. I will always keep you informed, to the best of my ability, of any possible risks as we make treatment decisions together. I will also assist you in getting to another treatment resource if, at any time, you decide you would like to make a treatment change. My belief is that any person, who has a desire to heal and/or change, can do so with proper help and support. Ultimately, the decision to make changes is yours. I am here to guide you and assist you on the journey.

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Unfortunately, there are no guarantees that any or all of your problems will be remedied by pursuing treatment with me. It is quite possible that you may experience stress, strained relationships, and other difficulties as a result of working in therapy, especially as you share painful feelings and thoughts that can cause unpleasant internal experiences. Growth is difficult, and often things feel worse before they feel better. You may experience anxiety as you are challenged to make major life decisions and/or changes. It is helpful to talk about these issues as they surface. For couples working in couple's therapy, there is no guarantee that therapy will ensure the continuation of the relationship. Research does show, however, that couples therapy improves the odds of relationship success. Finally, parents whose children participate in individual or family therapy may experience anxiety about the issues their children present to me in therapy. I am very respectful of parental roles and know how difficult parenting can be. My agenda will always be to assist families and couples in repairing damaged relationships whenever possible. Please know that change is slow, and often patience is required by both the client/s and therapist as this process continues. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Boundaries of the Therapeutic Relationship

The therapeutic relationship is unique to any other kind of relationship. For your protection and to preserve the integrity of our work, there are certain boundaries, which are held in therapy. You are expected to come to therapy, live up to your financial obligations, and be honest in our work together. You will never be asked to engage in any kind personal relationship with me, and I would be unable to do so with you. Although therapy work can be extremely personal and meaningful, the relationship will always remain professional. We will only meet in my office and only at scheduled times. Even once therapy is terminated, we will be unable to have a relationship other than a therapist/client relationship. This ensures the preservation of the therapeutic relationship if you should ever choose to return to therapy. We can discuss any particular feelings you may have in response to these therapeutic boundaries. In fact, this is an important part of the therapy process if and when it becomes an issue.

Confidentiality

The session content and all relevant materials related to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Children/Adolescents

When working with children or adolescents, I do not reveal to parents everything that a child or an adolescent tells me because this would interfere with the need to establish trust and rapport with kids. If a child or adolescent however, tells me anything that makes me seriously concerned about his/her safety and well-being or the safety and well-being of someone else, the child or adolescent's only choice regarding confidentiality is to participate or not to participate in telling

his/her parents. without consent of both, including for divorce proceedings. This also means that I will not hold individual confidences of either party that will jeopardize my allegiance to both parties in the couple.

Couples/Family

When I am working with individuals, the individual holds the right to confidentiality. When I am working with couples, or a family with two legal guardians, I am obligated to preserve confidentiality on behalf of the couple. This means that I will not release any information about either member of the couple

Office Polices: Scheduling and Cancellations

All scheduling is done by me; therefore any cancellations or appointment changes must go through me. The best way to reach me regarding scheduling is through my voicemail or text at (479) 957-0189. You can also email me at katiefreeman.lcsw@gmail.com. **For more timely communication voice mail and text is preferred over email.** Cancellations must be made at least 24 hours in advance in order to avoid being charged for the appointment time unless in the event of a mutually agreed upon emergency. Therapists/psychiatrists schedule blocks of time. If someone doesn't show up, we cannot see another client. That time is lost. I know this can be an emotional and controversial subject. You are not being blamed; it is the structure of a business. Please note that no insurance companies reimburse for missed appointments. Also, because wireless communication is not 100% reliable, my policy is that no appointment should be considered cancelled unless it is confirmed by me in a written response. I would also appreciate a written confirmation that you have heard from me about appointment changes.

Electronic Communication

In daily practice, I may use facsimile, email correspondence, other written correspondence (for example progress reports to third party payers), and cellular telephone service. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Emergency Needs

I do not provide emergency services. If for some reason, you call and do not get a response, and are experiencing a genuine emergency, you are advised to call 911 or go to your nearest mental health facility or emergency room. Springwoods has a 24 hour emergency walk in assessment center. They can be reached at (479) 973-6000. If you require hospitalization, I will stay in touch with your treating mental health professionals with your permission. We can resume outpatient treatment after an assessment of your status and needs. There is no charge for a brief (10 minute) phone check-in if there is an emergent need. However, you will be charged accordingly for a longer session or phone consultation.

Return Calls
Unless my voice mail states otherwise, I check messages regularly both weekdays and weekends. On weekends however, I only return calls of an urgent nature. I will always try to return calls within 48- hours on the weekdays.

The Appointment Hour
A therapy "hour" consists of 50-55 minutes of therapy time. Often times, more time than that is needed, and arrangements can be made for longer therapy sessions, and the fee will be adjusted accordingly. If I am late for an appointment, I will either complete with you the full time of your appointment (assuming your schedule permits this) or owe you the extra time. If you are late, the appointment will end at its scheduled time and you are responsible for full payment.

Termination and Follow-up
Termination is an important process in psychotherapy. If you are ready to begin the process of terminating, we will discuss this at length and spend several sessions putting closure on our work together. Terminating treatment is usually up to the client. There are occasions when I may initiate termination. The reasons for this decision would be discussed with you and would include an explanation. Possible reasons for therapist termination of treatment include a failure on your part to comply with the mutually developed treatment goals and procedures; the realization that you are not benefiting from therapy; failure on your part to pay your bill; any violent, abusive, threatening, or litigious behavior on your part; and/or if the therapeutic relationship is compromised in any way due to unforeseen circumstances. Any non-voluntary termination will be accompanied by an appropriate referral.

Client Rights

- You have the right to information regarding my training and professional credentials.
- You have the right to be treated by me in a consistently competent, ethical and respectful manner.
- You have the right to a personal, individual assessment of your treatment needs in which your expertise about yourself is as important as is my professional opinion about you.
- You have a right to referrals to other competent professionals and services when this is indicated by your treatment needs.
- You have a right to ask questions about the approach and methods I use and to decline the use of certain therapeutic techniques.
- You have the right to confidential treatment except in circumstances already described.
- You have the right to information regarding anticipated length of treatment and prognosis if you stop treatment. You have the right to stop receiving therapy from me without any obligation other than to pay for the services you have already received unless you are dangerous to yourself or someone else.
- You have the right to resume services following termination after assessment.
- You have the right to discuss your treatment, concerns, questions, complaints with me.

Please sign below to acknowledge that you have read and that you understand the information described herein and that you have discussed with me any part of the information you do not understand. The original copy will remain in my file and I will give you a copy for your records if you desire a copy.

_____	_____
Patient Name	Birth Date
_____	_____
Patient or Parent/Guardian Signature	Date
_____	_____
Therapist Signature	Date

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phone (479)957-0189
fax (479)431-2548

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Address: _____ City/State: _____ Zip: _____
Cell: _____ Work: _____ Home: _____
May we leave a msg? ☐ Yes ☐ No May we leave a msg? ☐ Yes ☐ No May we leave a msg? ☐ Yes ☐ No
Birth Date: _____ Age: _____ Marital Status: _____
Gender: ☐ Female ☐ Male Employer: _____ SSN: _____

SPOUSE INFORMATION or CUSTODIAL PARENT/GUARDIAN INFORMATION (if the patient is a minor)

Name: _____ Birth Date: _____ SSN: _____
Relationship: _____ Phone: _____

ADDITIONAL CUSTODIAL PARENT/GUARDIAN INFORMATION

Name: _____ Birth Date: _____ SSN: _____
Relationship: _____ Phone: _____

EMERGENCY CONTACT INFORMATION (if different than Spouse/ Custodial Parent/Guardian)

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

☐ *NO INSURANCE / PRIVATE PAY*

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other
Insurance Company: _____ Insurance Phone: _____
Policy Holder's Name: _____ SSN: _____ Birth Date: _____
Policy Holder's Address: _____ City/State: _____ Zip: _____
ID / Policy#: _____ Group/Plan/Division #: _____
Employer: _____

SECONDARY INSURANCE INFORMATION

☐ *NO SECONDARY INSURANCE*

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other
Insurance Company: _____ Insurance Phone: _____
Policy Holder's Name: _____ SSN: _____ Birth Date: _____
Policy Holder's Address: _____ City/State: _____ Zip: _____
ID / Policy#: _____ Group / Plan / Division#: _____
Employer: _____

AUTHORIZATION FOR INSURANCE PAYMENT

My signature below indicates that I agree to authorize payment of insurance benefits to the service provider, authorize the release of any information necessary to process insurance claims, and accept payment responsibility of the portion of the bill which insurance does not cover.

Patient / Custodial Parent / Guardian Signature: _____ Date: _____

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PATIENT RESPONSIBILITY

I, _____ understand that I have contracted for services with Katie Freeman, LCSW and that I alone am responsible for paying the amount I am billed for services. In particular,

1. I understand that Katie Freeman, LCSW provides insurance filing as a courtesy and a convenience to me and/or will seek authorizations from my health care provider; however, these activities do not guarantee that my insurer will pay. I understand that at any time I am free to file my own insurance, in which case full payment of fees will be required at the time of service.

2. I understand that Katie Freeman, LCSW will attempt to help me understand my insurance or managed care benefits and procedures, but that denial of benefits by my insurance means that I am fully responsible for the contracted amount.

3. I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for:
   - Obtaining the initial referral to the provider, if needed.
   - Ensuring I have pre-certification of visits, if needed.
   - Knowing limits regarding my deductible.
   - Keeping track of benefit limits. Keeping track of my benefit limits entails knowing any limits on my policy and ensuring that I do not exceed those limits (e.g., some insurers set a maximum of 20 mental health sessions per year). If I exceed my limits and my insurer refuses to pay. I am responsible for the amount refused. Also, I understand that if I am seeking another social worker, psychologist, or psychiatrist, those sessions may count against my mental health benefits. I also realize that while my managed care provider may authorize visits as appropriate for me, that does not mean that they will necessarily pay for those visits (e.g., some insurers will authorize 25 visits when they will only pay for 30 visits).

4. A fee of $150 per scheduled hour will be charged if I do not give a 24 hour notice (during normal business hours) to cancel an appointment, with the exception of mutually agreed upon emergencies. Insurance cannot be billed for this fee, as they will not pay for missed appointments.

5. I understand that if my policy changed or if I switch insurance companies, I should inform Katie Freeman, LCSW immediately. If the office does not have the proper information and cannot collect payment from the insurer, I am responsible for the amount the insurance company will not pay.

6. I also understand that in the instance of my account getting turned over to collections that I am responsible for the entire bill plus 100% of collection fees.

_____ _____

Patient Name Birth Date

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

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Authorization to Contact

Patient Name: _____ Birth Date: _____

If applicable:
Parent / Guardian Name: _____ Phone: (_____) _____ - _____

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact Katie Freeman, LCSW will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change. In the event that client chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone, wire to wire fax, or mail. In this case, communication may not be as timely.

Voice communication to client's cell/smart phone for:

Scheduling appointments	____ allowed	____ not allowed
Appointment reminders	____ allowed	____ not allowed
Between session contact	____ allowed	____ not allowed

Voice communication from Katie Freeman's cell/smart phone for:

Scheduling appointments	____ allowed	____ not allowed
Appointment reminders	____ allowed	____ not allowed
Between session contact	____ allowed	____ not allowed

Fax communication to client's non-secure fax or E-fax for:

Scheduling appointments	____ allowed	____ not allowed
Appointment reminders	____ allowed	____ not allowed
Between session contact	____ allowed	____ not allowed

If permitted, list permitted fax numbers: _____

Text communication to client's cell/smart phone for:

Scheduling appointments	____ allowed	____ not allowed
Appointment reminders	____ allowed	____ not allowed
Between session contact	____ allowed	____ not allowed

Text communication from Katie Freeman's cell/smart phone for:

Scheduling appointments	____ allowed	____ not allowed
Appointment reminders	____ allowed	____ not allowed
Between session contact	____ allowed	____ not allowed

Contact via the client's email:

Scheduling appointments	____ allowed	____ not allowed
Appointment reminders	____ allowed	____ not allowed
Between session contact	____ allowed	____ not allowed

If permitted, list permitted email address(es): _____

Statement of Validation.
I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.

_____ _____
Patient Name Birth Date

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Therapist Signature Date