Your Space Counseling, LLC

1621 Tongass Avenue, Suite 305
Ketchikan, AK 99901
907-247-5000
907-247-5001-Fax

Thank you very much for considering Your Space Counseling for your mental health needs.

Please fill out the following information. Answer the questions as best you can. Any areas that are confusing can be addressed when we meet.

Our first meeting will last between one to two hours. Ideally, I like to meet with everyone in the immediate family. I will ask general questions and also questions regarding your child's early history. If you and you're your child feel comfortable, I will request to meet with your child separately, while you wait in the waiting area. I may then ask your child to wait in the waiting area, while I meet with you. At the end of the meeting, I will speak with everyone and relay my thoughts regarding therapy.

Once therapy begins, I will arrange weekly appointments. I make every effort to accommodate you and your child; however, there may be times during the day that are unavailable. Afternoons tend to get booked quickly. After we agree on a day and time, I will hold this appointment for your child each week. I charge $75 for missed appointments that are not due to illness or emergency.

Due to the nature of confidentiality I will not be able to discuss what your child says or does in the therapy session, unless your child is thinking of harming themselves, others or if someone is harming your child. However, I will meet with you to provide updates on how I think the therapy is going and I will ask you for your thoughts regarding therapy. Depending on your insurance benefits these meetings may be covered and they may not. You will be responsible for the out of pocket expense.

I am happy to answer any questions you may have. Please do not hesitate to contact me.

Sincerely,
Roseann Lynch LPC, NCC, RPT, CDC 1
Nationally Certified Counselor, Licensed Professional Counselor,
Registered Play Therapist, Chemical Dependency Counselor 1

Your Space Counseling

1621 Tongass Avenue, Suite 305
Ketchikan, AK 99901
907-247-5000
907-247-5001- Fax
info@lynchtherapy.com

Today's Date:_____

Legal Name of Child:_____
D.O.B._____
MailingAddress:_____
Home Phone:_____ Cell Phone:_____
Referred by:_____
Emergency Contact:_____
Emergency Contact Phone:_____

Mother's Name:_____ Home Phone:_____
Address:_____ Cell
Phone:_____Email:_____

Father's Name:_____ Home Phone:_____
Address:_____ Cell Phone:_____
Email:_____

Legal Guardian:_____Home Phone:_____
Address:_____ Cell Phone:_____
Email:_____

Name of person completing this form:_____

What problem would you like help with?_____
_____

When did this problem first begin?_____
_____

What has been tried to solve this problem?_____
_____

Please list your child's medical conditions:_____
_____

Please list the name of your child's doctor, medications and dosages:_____
_____

Please list previous mental health treatment:_____
_____

Please list any accidents, falls concussions:_____
_____

Please list everyone who currently lives in your home:_____
_____

How does your child get along with those who live in the home?_____
_____
_____

How does your child get along with peers?_____
_____
_____

***What school does your child attend*?_____**
***Grade:*_____ *Teacher's name*:_____**
***Please list academic or behavioral concerns*:_____**
_____

***Please circle all that apply for your child*:**

Anger outbursts	Worries too much	Sleeping too much
Sleeping too little	Refuses to obey adults	Sadness
Irritability	Not their usual self	Eating too much
Eating too little	Excessive Fear	Poor Concentration
Difficulty following directions		Frequent stomach aches
Frequent headaches	Toileting Problems	Unable to sit still
Daydreams	Lies	Has an imaginary friend
Stares off into space	Nightmares	

Sensitivity to:
Light, Sound, Touch, Fabric, Food, Tastes/Textures

Jumps a lot on beds	Bumps into others/objects	Grasps items tightly
Drops things	Mouths, licks or chews on non-food items	
Has poor balance	Difficulty following multi-step directions	

***Is there anything else you would like me to know about your child?*_____**
_____
_____
_____
_____

*If you need to cancel or reschedule an appointment, please give **24 business hours** advance notice, **OTHERWISE YOU WILL BE BILLED AT THE HOURLY RATE.***

Mental Health counseling is a medical service and as such, there is no guarantee that your insurance company will cover all recommended services. **Fees**: Intake-$275, Individual Therapy-$150, Family Therapy-$180, Couples Counseling- $180, Interactive Therapy-$175

******Unpaid balances** will be sent to Cornerstone Collections.*

*In the event your check is returned for insufficient funds, you will be charged the bank fee not to exceed **$35.***

I agree that I am financially responsible for all unpaid balances, collection fees; interest earned fees and attorney fees should this account be sent to a collection service.
Signature(s)_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*
Signature(s)_____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I consent that _____ may be treated as a client by Your Space Counseling. At times it may be necessary to schedule appointments during school hours. I ask for your cooperation to provide the timeliest treatment for you and your child.

Signature(s)_____Date_____

I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

Client's Rights

Right to request how I contact you
It is my normal practice to communicate with you at your home address and daytime phone number you gave me when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes I may leave messages on your voicemail. You have the right to request that I communicate with you in a different way.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in my medical records. To request access to your billing or health information, contact me. Under limited circumstance I may deny your request to inspect and copy. If you ask for a copy of any information, I may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask me to add information to amend the record. I will make a decision on your request within 60 days, or some cases within 90 days. Under certain circumstance, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. To request an amendment, you must contact me. I will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, I have made related to your medical information, except for information I used for treatment, payment, or health care operational purposes or that I shared with you or your family, or information that you gave me specific consent to release. It also excludes information I was required to release. To receive information regarding disclosure made for a specific time period no longer than six years after today's date, please submit your request in writing to me. I will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to me. However, I am not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact me personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. You will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from me.

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2010

Your Space Counseling has been and will always be totally committed to maintaining client's confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes my policies related to the use and disclosure of your healthcare information.

Use and disclosures of your health information for the purposes of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows me to use and disclose your health information for these purposes.

TREATMENT: I may need to use or disclose health information about you to provide, manage or coordinate your care or related services; which could include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS: I may need to use information about you to review your treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Alaska State Law, I am obligated to report this to the Office of Children's Services. I may also disclose information without your consent if you provide information that informs me that you are in danger of harming yourself or others and is someone is harming you, information to remind you of /or to reschedule appointments or treatment alternatives, information shared with law enforcement if a crime is committed on my premises or against myself or as required by law such as a subpoena or court order.

Thank you for choosing Your Space Counseling. Your first appointment will take approximately 60-90 minutes. Each therapy session will occur for 45-60 minutes. Marriage or Family sessions are generally 50- 90 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

Information about me:
I am Roseann Lynch. I have earned a Bachelor of Science Degree in Teaching from the University of New York: York College, a Masters Degree in Counselor Education from the University of New York: Queens College and an Advanced Graduate Certificate in Marriage, Family and Couples Counseling from Regent University. I am licensed by the State of Alaska as a Licensed Professional Counselor. I have experience working with infants, children, adolescents, families, couples and adults. I have credentials as a Nationally Certified Counselor, Registered Play Therapist and Chemical Dependency Counselor- 1. I utilize Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing Therapy, Sensorimotor Psychotherapy, Sand Tray Therapy, Sensorimotor Psychotherapy and Child Centered Play Therapy during individual, group, couples and family therapy sessions; although other treatment approaches may be used depending on the person or condition.

EMERGENCY SITUATIONS:
In the event I become incapacitated or deceased, Patti Hauser, Licensed Clinical Social Worker and Chemical Dependency Counselor 2 will contact you.
If an emergency situation for which you feel immediate attention is necessary and I am unable to return a call within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Your Space Counseling will follow up with those emergency services with standard counseling and support to the client or the client's family.

FINANCIAL/INSURANCE ISSUES: *As a courtesy I will bill your insurance company, HMO, responsible party or third party payer for you. I ask that every client authorize payment of medical benefits directly to Your Space Counseling.*

Mental Health Billing Services (MHBS) will bill your insurance company for services I provide. There may be times when your insurance does not cover a service or your deductible has not been met. When this happens, MHBS will send you a bill for payment. If you have questions regarding your coverage, please contact your insurance company and if you have questions regarding a bill, please contact: MHBS at 907-258-6427.
******Unpaid balances*** *can incur the risk of being sent to Cornerstone Collections.*
Fees: Intake-$275, Individual Therapy-$150-180, Family Therapy-$180, Couples Counseling- $180,

Interactive Therapy-$175****Same Day Cancellations:*** will be charged $75.

For Parents/Guardians:

I will make time to meet with you once I establish a therapeutic relationship with your child. This usually occurs after the fourth or fifth session. I will either set time aside during your child's regularly scheduled appointment to meet with you or by scheduling a separate day to meet with you. Meetings arranged outside of your child's regularly scheduled appointment are billable to your insurance company and you will be responsible for any co-pay or co-insurance required by your insurance company or any payments not covered by your insurance company.

During this meeting, I will update you on how I believe therapy is progressing and I will want to know how you feel about your child's progress. We will continue to meet until therapy is completed.

Please keep in mind that confidentiality is as important to your child as it would be to you if you were receiving counseling. Refraining from asking your child questions about the session will send a message that you respect the work your child is engaged in. If your child desires to tell you about a session, he/she will not need to be prompted.

I will make every effort to assist your child in speaking with you about any concerning behaviors, however, unless your child is in imminent danger or plans to harm others, I am bound by the confidentiality standards of my profession.

If you have important information you wish to share with me regarding your child, please phone me or arrange to meet with me on a day that is separate from your child's regularly scheduled counseling session.

I look forward to working with you and your family.