CHRISTYKANE PsyD

Dr. Christy Kane, LLC
5455 W 11000 North Suite 204
Highland, UT 84003
385-223-0777

WELCOME TO DR CHRISTY KANE

Our Approach to Therapy: Therapy is a collaborative process. The progress you make will depend largely upon your investment in your growth and communication with your therapist.

Fees & Payments: Payment for all appointments is due at the time of service. Payment can be completed via credit card on file or personal check. Please remember that you are responsible for payment of all fees whether or not your health insurance provides reimbursement.
first visit evaluation is $175.00, and then $150.00 per following session.

Insurance Reimbursement: Dr. Christy Kane LLC is happy to assist with insurance reimbursement for all insurances. You should be aware that most insurance plans have an annual deductible, which must be met prior to reimbursement. You will be responsible to pay for each session if your deductible has not been met.
Some insurance plans require you to call prior to the first visit to obtain authorization for a specified number of visits. If you fail to obtain authorization prior to your initial therapy session, then you will be responsible for payment. If you have questions, please discuss your policy with your insurance provider directly and your therapist. We cannot guarantee the amount of reimbursement/insurance processing time.

Cancellations: Cancellations must be made ***48 hours in advance to avoid charge.***
Missed appointments ***will be charged $100.00.***
There will be a $25 charge for each personal check or credit card rejection.

Benefits of Counseling: Participation in counseling can lead to the resolution of the concerns brought to therapy. Further benefits may be a better ability to cope with marital, family and other interpersonal relationships, and/or a greater understanding of personal goals and values.

Risks of Counseling: You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can lead to discomfort as well as relationship changes. Further, counseling may not, by itself, resolve your concerns. Mental Health Professionals at Dr. Christy Kane LLC will do their best to assess progress and provide referrals

Crisis: We are not a crisis service. If you are experiencing a life-threatening emergency, please call 911 or go to the nearest emergency room. You can also contact the National Alliance on Mental Illness (NAMI) for support by calling 800-950-6264 or by texting NAMI to 741-741.

Please fully complete all forms

CONFIDENTIAL HEALTH INTAKE FORM

Please completely fill out all forms. Leave nothing blank.
If something does not apply or you do not wish to provide information write "N/A"

Full Legal Name: _____ **DOB:** _____

Home Address: _____ **City:** _____ **Zip:** _____

Cell Phone: _____ **Ok to contact?** _____ **Leave message?** _____

Email: _____ **Work Phone:** _____

Referred by: _____
In case of emergency please notify:

Name: _____ **Phone:** _____ **Relationship:** _____

Primary Care Physcian: _____ **Phone:** _____
I give permission for Dr. Christy Kane LLC to provide updates to my physcian: Yes No

MENTAL HEALTH

Have you seen a therapist before? Yes No **When?** _____

Current reason for seeking treatment: _____

_____

_____

How do you currently cope with the reasons described above? _____

_____

What has happened to cause you to seek help now? _____

_____

What do you hope to acheive as a result from treatment? _____

_____

_____

Do you currently have thoughts of harming yourself? Yes No
Have you in the past? Yes No If yes, how long ago? _____

Do you currently have thoughts of wishing you were dead? Yes No

Do you currently have urges to hurt or kill someone else? Yes No

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SYMPTOMS CHECKLIST

Please check all that apply

Abuse/trauma - phsyical, sexual, emotional, neglect
Anger, hostility, frequent irritability, agression, or violence
Anxiety, nervousness, or constant worrying
Attention, concentration, distractability
Career concerns, goals, and choices
Childhood issues
Compulsions and/or obsessions (thoughts and actions that repeat themselves)
Decision-making, indecision, mixed feelings, putting off decisions
Depression, numbness, sadness, or crying spells
Divorce, sepration, infidelity/affairs, or marital conflict
Drug use - prescription medications, over-the-counter medications, street drugs
Eating problems - restricting, binging, changes in appetite, purging, or compulsive eating
Fatigue, tiredness, low energy
Fears and phobias
Financial troubles
Grieving, mourning, death, losses
Guilt
Hallucinations
Health concerns, illness, and physical problems
Impulsivity, outbursts, or loss of control
Loneliness
Memory problems
Mood swings
Oversensitivity
Panic or anxiety attacks
Perfectionism
Procrastination or lack of motivation
Relationship issues (with friends, coworkers, or relatives)
School problems
Self-esteem
Self-neglect or poor self-care
Sexual concerns - dysfunctions, conflicts, addictions, identiy issues, etc.
Sleep problems (too much, too little, insomnia, nightmares)
Spiritual, religious, moral, ethical issues
Stress and tension
Suspiciousness
Suicidal thoughts or feelings
Withdrawal and isolation

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MEDICAL HISTORY

Do you have any physical health concerns to discuss with your provider? Yes No

Please list significant medical problems, and indicate if you are receiving treatment for them:

_____

_____

_____

Do any of these problems affect your everyday life? If yes, How so? _____

_____

_____

Describe any surgeries/hospitalizations for serious illness/injuries (What, where, when, etc.):

_____

_____

_____

Please list any psychiatric hospitalizations (place, approximate date): _____

_____

List all medications you currently use and their dosage (amount & times per day):

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Were there any complications with your birth? _____

Did you have childhood developmental issues? _____

How many days per week do you exercise? _____

How many minutes per day? _____

What type of exercise? _____

How many caffeinated drinks per day? Coffee _____ Energy _____ Soda _____ Tea _____

FOR WOMEN ONLY: Are you pregnant or think you might be pregnant? Yes No

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FAMILY BACKGROUND

Marital Status (circle one) : Married Living with partner Single Divorced/Separated Widowed
Other: _____

How do you identify your sexual orientation? _____

Comments regarding stresses in current or previous relationships? _____

_____

_____

Have you ever been abused by a romantic partner? Yes No

Does this apply to your current relationship? Yes No

Do you feel safe? Yes No

Is there a history of mental illness in your family? If yes, who and what concerns? _____

_____

_____

Who were you raised by? _____

Were you adopted? Yes No **At what age?** _____

What family member were you closest to as a child? _____

Who are you closest to now? _____

Check the statement that most closely describes the family you grew up in:

overly close family	frightening, scared to make mistakes
comfortably close family	everyone was in everyone else's business
no "breathing room"	boundaries were not respected
supportive	distant, everyone did their own thing
not a lot of support	angry, lots of fighting/hostility
violence and physical abuse	shared many positive experiences together
no privacy	verbal abuse and conflicts

Any biological relatives with substance abuse? Yes No

Please explain: _____

_____

Anyone in your family attempted or committed suicide? Yes No

Please explain: _____

_____

SUBSTANCE USE

Have you experienced a problem with drugs, alcohol, or prescription medications? Yes No

Please explain: _____

_____

Have you ever been treated for substance use? Yes No

Please explain: _____

_____

Has anyone (friends, family, coworkers, doctors, etc.) expressed concern that you may have a problem with substance use? Yes No

Please explain: _____

_____

Has drinking/drug use caused problems in any of these areas of your life?

family	legal	financial	employment
school	emotional	phsyical health	social

EMPLOYMENT/EDUCATION

Check all that apply: employed full-time employed part-time stay-at-home parent student unemployed retired disabled other _____

If employed, what type of work do you do? _____

_____

Your income: _____ **Total household income:** _____

Highest degree completed in school _____

Have you served in the military? Yes No **If yes, what branch?** _____

Client Name (please print): _____ **Date:** _____

Parent/Guardian of client (if under age 18): _____

Signature: _____

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CLIENT RIGHTS

It is important to know you have many rights and responsibilities when you enter counseling. Please read and agree to these rights and responsibilities by signing below.

You have a right:

- to considerate and respectful care, which includes freedom from any physical, sexual, fiduciary (financial), or psychological abuse including humiliating, threatening, and exploiting actions;
- to understand what your problem is, what treatment is recommended and why, who will give the treatment, and what outcome to expect;
- to be involved in a process of informed choice, informed refusal, and/or expression of choice related to preference of your treatment services, choice of service provider and participation in research projects;
- to expect that all communications and records pertaining to your care will be treated as confidential; to have continuity of care when you are referred for services outside this agency;
- to examine and receive an explanation of your bill.
- to participate in all aspects of your treatment and development of your treatment plan.
- to have access to self-help and advocacy support services.
- to voice complaints or lodge an appeal without recrimination.
- to all legal protection and due process for status as an outpatient, both voluntary and involuntary, as defined under Utah law

Your responsibilities are:

- to be honest in your presentation of your problems and to tell those working with you how you feel about what is happening to you.
- to be actively involved in the development of your treatment plan that will outline your problems, needs, goals, and expected outcome(s);
- to be considerate of others and their privacy;
- to present to your counselor any questions, complaints or concerns about your counseling plans or goals so that you may reach an agreement on any problem hindering your progress.

Client Name: _____ Date: _____

Signature: _____

CONFIDENTIALITY & HIPAA NOTICE

Please read fully and sign to confirm receipt and understanding.

Confidentiality means that Dr. Christy Kane, LLC has a responsibility to safeguard information obtained during counseling. **Use and Disclosure for Treatment, Payment, and Health Care Operations** within Dr. Christy Kane LLC protects the privacy of your Personal Health Information (PHI)—health information that could identify you.

- **"Use"** applies only to activities *within* Dr. Christy Kane, LLC (office, clinic, group, etc.) such as sharing, applying, utilizing, examining, employing, analyzing information that identifies you.
- **"Disclosure"** applies to activities *outside* the Dr. Christy Kane, LLC practice, such as releasing, transferring, providing information about you to other parties.
- **"Treatment"** is when Dr. Christy Kane, LLC provides, coordinates, or manages services related to your health care. An example of treatment would be when Dr. Christy Kane, LLC consults with another health care provider, such as your family doctor or another therapist.
- **"Payment"** is when Dr. Christy Kane, LLC submits PHI on your behalf. Insurance companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records. Dr. Christy Kane, LLC submits insurance claims on your behalf to ease the process with the insurance company. This is a courtesy service.
- **"Health Care Operations"** are activities that relate to the performance and operation of the Dr. Christy Kane, LLC practice. Examples include: quality assessment, improvement activities, business-related management such as audits, administrative services, case management, and coordination of care.

You must sign a **Release of Information** before information about you is given to anyone, except as mandated by law. In certain situations, Dr. Christy Kane, LLC is required by law to reveal information without your consent and without notification to you. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor. In such cases, Dr. Christy Kane, LLC may advise a parent or guardian of a minor, with or without the minor's consent, of the treatment needed.
- We may disclose confidential information in proceedings brought by a client against a professional.

You have the right to:

- request a restriction on certain uses and disclosures of your information
- inspect and obtain a copy of your health record
- amend your health record as provided by regulation
- obtain an accounting of disclosures of your health information as provided by law
- request communications of your health care information by alternative means or locations
- revoke use or disclose health information except to the extent that action has already been taken

Client Signature: _____ Date: _____

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PAYMENT AGREEMENT

Client Name: _____ **Social Security #** _____

Name of insured: _____ **Social Security #** _____

DOB for insurance carrier: _____ **DOB for client:** _____

Billing Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

$175.00	Per hour for Intake/Diagnostic Assessment (first visit)
$150.00	Per hour for Individual/Couples/Family Counseling (following visits)
$58.00	Per hour for Group Session
$200.00	Per hour for Psychiatrist - Medication/Somatic Service
$100.00	I also understand that there is a $100.00 charge for missed appointments or for appointments that are not canceled 48 hours in advance.

Note: Your credit card information is required for the purpose of charging co-pays, no shows for appointments, and to cover any balances not covered by insurance.
Please complete and initial:

_____ **I have provided my credit card information to Dr. Christy Kane, LLC**

_____ **I have provided a copy of my insurance card and/or insurance information**

I understand that certain insurance policies may pay a portion of the fees assessed for services received. I agree to provide copies of membership card(s) and claim forms when required. I understand that I am responsible for the amount not covered by my insurance up to the full fee for service. I also understand that I am still responsible for my co-pay amount to be paid at the time services are received. If the sum received through insurance and client fee payments exceeds the fee payments or the fee for service, the excess paid will be reimbursed to the client after all services, and claims for services, are processedI authorize payment of benefits directly to Dr. Christy Kane, LLC for services rendered. I also authorize release of information (for insurance payment purposes only) that is protected by Federal Confidentiality rules (42 CFR, Part 2, Section 2.31 of PL-03-282).
I also certify that I have read, understand, and have received a copy of Dr. Christy Kane LLC services. payment agreement, consent to treatment and confidentiality statement, and a copy of the Client Rights and Grievance Procedures. I understand that the Dr. Christy Kane LLC clinic does not discriminate against any individual based upon race, color, creed, sex, sexual orientation, national origin, religion, disability or economic situation including the ability to pay for services. Dr. Christy Kane LLC does not tolerate any form of harassment of clients or staff by any individual at any time. Dr. Christy Kane LLC is an equal opportunity employer and equal provider of services.

Client Name: _____ Date: _____

Signature: _____

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MEDICAL RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

SSN: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Email: _____

INFORMATION REQUESTED FROM

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____ Email: _____

SEND INFORMATION TO

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____ Email: _____

I, _____ (Name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility/entity.

_____ _____

Printed Name Date

_____ _____

Signature Date

_____ _____

Signature of parent/guardian if under age 18 Date