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

WELCOME

We're so glad you're here. We can't wait to help you on your journey.

Costs: Initial evaluation $175.00, then $150.00 per session
Payment for all appointments is due at the time of service via credit card or personal check. Please remember that you are responsible for payment and knowing your co-pay amount. Clients unsure of co-pays and/or insurance coverage will be charged full price ($175) and offered reimbursement or credit based on insurance response.
Prior to reimbursement, your annual deductible must be met. If your deductible has not been met, you will be responsible to pay for each session. Please note, some insurance plans require authorization before engaging in therapy or have a specified number of visits permitted. Clients who do not receive authorization or who exceed the allotted number of visits will be responsible for payment. If you have questions about your mental health coverage with your insurance, please talk with your insurance provider directly. Dr. Christy Kane LLC cannot guarantee reimbursement amounts nor insurance processing time.

Cancellations or reschedules must be made **48 hours in advance to avoid charge.**
Missed appointments, cancellations and reschedules made 48 hours or less before an appointment **will be charged $150.00**

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 to other sources if that is deemed necessary and appropriate.

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.

PAYMENT AGREEMENT

Note: Please provide your insurance card to our front desk the day of your appointment. We will make a front & back copy of it for your patient file.

To contact our billing department email sharalynn@drchristykane.com or call 385-204-4405

Patient Name (Please Print): ______________________________ DOB: ____________

Insurance Company Name: ____

Policy Holder Name: ________________________ Policy Holder DOB: ______________

Insurance Policy Number: _________________ Policy Member ID: __________________

Group # ________________ Copay Amount: _____________

Policy Holder 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

I also understand that there is a **$150.00 charge for missed appointments or for appointments that are not canceled/rescheduled 48 hours in advance.** Note: Credit card information is required for charging co-pays, no shows for appointments, and to cover any balances not covered by insurance.

_________ (please initial) I have provided my credit card information to Dr. Christy Kane, LLC

_________ (please initial) 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 processed. I 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 Signature: ____________________________ Date: ______________

CHRISTYKANE PsyD

CONFIDENTIAL HEALTH INTAKE FORM

If something does not apply or you do not wish to provide information write "N/A"

Please print legibly & fully complete all forms

Full Legal Name: ______________________________ DOB: ____________________

Home Address: __________________________ City: __________ Zip: _______

Cell Phone: ____________________ Ok to contact and leave messages? yes / no

Email: ________________________ Work Phone: ______________

Referred by: ___________________________ I consent to telehealth services yes / no

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

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MENTAL HEALTH

Have you seen a therapist before? yes / no When? __________________________________

Current reason for seeking treatment: ____

____

How do you currently cope? ____

____

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, when? ____________________

- 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

SYMPTOMS CHECKLIST - *Please check all that currently apply*

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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

Does your physical affect negatively affect your everyday life? yes / no

How so? ____

____

What treatment are you receiving for these conditions? ______________________

____

Describe any surgeries or hospitalizations for serious illness or injuries ______________

____

____

Please list any psychiatric hospitalizations (when & where): ______________________

____

List your current medications, dosage, & how many times per day you take it:

1. ____________________ 5. ____________________

2. ____________________ 6. ____________________

3. ____________________ 7. ____________________

4. ____________________ 8. ____________________

Were there any complications with your birth? yes / no

Did you have childhood developmental issues? yes / no

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 Drinks _______ Soda _______ Tea _______

FOR WOMEN ONLY: Are you pregnant or think you might be pregnant? yes / no

FAMILY BACKGROUND & RELATIONSHIPS

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Race (circle all applicable): American Indian/Alaska Native Asian Black/African American Hispanic/Latino Native Hawaiian/Pacific Islander White/Caucasian

Marital Status: Married Living with partner Single Divorced Separated Widowed

How do you identify your sexual orientation? ______________________________

Stresses in current relationship(s)? ____

____

____

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? yes / no

Who and what illness(es)? ____

____

Who raised you? ____

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(s) 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

Anyone in your family attempted or committed suicide? yes / no

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 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 level of education ______________________________

Have you served in the military? yes / no

If yes, what branch?______________________________

I verify that the information contained herein is true and accurate

Client Signature: ______________________________ Date: ________________

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

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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

CHRISTYKANE PsyD

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).

- “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: __________________

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: Dr. Christy Kane LLC   Address: 5455 W 11000 N Suite 204

City: Highland   State: UT   Zip Code: 84003

Phone: 385-223-0777   Fax: 385-232-8079   Email: hello@drchristykane.com

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   _________________________________