CFCC
AND ASSOCIATES

A compassionate ministry for hope and healing

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We welcome you to CFCC & Associates, Inc., which does business as Christ First Counseling Center. As you visit our office, there are some features you might find of interest. CFCC is here to offer Christ-centered counseling, therapy, and education. CFCC has been designed with your convenience, comfort, and confidentiality in mind.

Convenience

The office is handicapped accessible and parking is convenient for all clients. Therapists offer additional appointment times during evenings and weekends for those who are unable to utilize regular daytime office hours. There is an automated telephone answering system for calling outside office hours.

Comfort

We have worked hard to create a comfortable office environment and a serene atmosphere in order to make your experience with us as pleasant as possible. Please help yourself to a cup of coffee or water and feel free to take any magazine or brochure you would like to keep.

Confidentiality

We are dedicated to maintaining your right to confidentiality. To maintain your right to confidentiality, we will not provide information to anyone regarding your treatment here without your permission, except in the following special circumstances:

1. Suspicion of child and elder abuse (as required by law)
2. If you present a danger to yourself or others (as required by law)

3. If you are a minor and your parent or legal guardian requests information (as required by law)
4. When we are court-ordered to release information
5. In the case of a medical emergency (when we would contact the person you list on page 1)
6. To collect unpaid balances on your account (in which case only identifying and balance information would be given but not information regarding your treatment itself)
7. For case/team consultations and supervisory purposes where no identifying information will be shared.

Your therapist may have occasion to use case information as examples when writing or speaking about therapy or related topics in an educational setting. In any event, information that could identify any specific client is never used in this context.

Please feel free to share any suggestions you may have as to how we can make your visit more pleasant. You may or may not have been to a therapist before. If this is your first experience with therapy, you may feel a bit nervous or apprehensive. That's very normal! Therapy is a process that allows you the freedom and privacy to discuss issues that are often painful or difficult with family and/or friends. Below are a few suggestions to help make your counseling experience more effective:

1. Before your scheduled appointment, write down questions, topics, or issues you would like to focus on in your session.
2. Communicate your expectations to your therapist so that you can work together toward your goals.
3. Provide ongoing feedback to us so that we know how you are doing (example: "I want to focus on my anger more," or "I like doing relaxation exercises.")
4. If you feel a need to increase or decrease the frequency of your sessions or to end counseling, feel free to communicate that to your therapist.
5. If you feel a need to bring a partner, relative, or friend in with you for your sessions, feel free to communicate that to your counselor.
6. If you have another professional involved in your care, (i.e. physician, chiropractor, attorney, etc.,) we would be happy to coordinate with them if you wish. It is not advisable to have more than one mental health counselor involved in your treatment at one time.
7. Try to make a commitment to remain in therapy and attend regular sessions for as long as you feel necessary. If you wait until you have a crisis, it will be more difficult to build long-lasting coping skills and will further restrict progress toward your goals.
8. If for any reason you would like to see a different therapist, please feel free to tell your therapist. We can provide you with names of therapists, within the same agency – or if you would like, we will provide you with a list of community referrals.

Informed Consent Contract

CFCC & Associates, Inc.

Welcome to therapy. It is our desire to work for and with you regarding that which brings you here. It is important for us to get to know each other and assess your situation and then, together decide what the best treatment approach would be. Your therapy sessions are strictly confidential by law. We must have your written permission to discuss your case outside of the office or with anyone other than you. We may discuss your case with the therapy staff of CFCC & Associates, Inc. When that occurs, only a clinical overview will be shared in order to get ideas about how to better help clients.

The exceptions to confidentiality rules include: (1) Information required by insurance companies (we will discuss this with you if you wish to use your insurance), (2) known or suspected abuse or neglect of a child; including children who witness domestic violence, (3) abuse or neglect of disabled or elderly adults, and (4) situations where we are concerned that you are a likely risk of grave harm to yourself or someone else. In those cases, we have the duty to warn potential victims, notify others who can keep you safe or arrange for your safety with authorities.

If we receive a subpoena, your therapist will alert you and we will further discuss what subpoena is and how it will impact your particular case. We must respond to the subpoena but cannot reveal information without your permission or an order from the court. We strongly believe that clients and their children's best interests require that therapy be a safe place to talk. People generally do not feel safe if they feel that the information revealed in therapy will be used in court, and so if a subpoena occurs, we will discuss this further.

If we see people individually as well as in couples or family situations, we will keep information confidential except for the above situations. However, if we believe that others within the family/relational unit deserve to have the information in order for us to continue progressing in therapy; we may encourage you to divulge the information and will work with you to do so. If you decide that you cannot share the information and your therapist believes that it is critical to the therapeutic process, they may tell you that they cannot continue as your therapist. In those situations, they will not divulge the information and they will give you additional appropriate referral information. We also want to make you aware that if you fail to make or keep an appointment within 90 days, your file will be closed and you will have to schedule a new intake appointment if you wish to return to see a therapist.

Parents have the legal right to receive information that their children share with their therapist during therapy sessions. However, in order for the children to feel safe with their therapist, we ask the parents do not request information. Your child's therapist may encourage children to share information and help them to do this, but they will not do it themselves unless they believe it is necessary to protect the life and wellbeing of the child. If you feel there are exceptions/concerns to this, please discuss it with us before scheduled therapy begins.

While it would be wonderful if everyone who attends therapy reaches the goals they desire, it is impossible to guarantee success. Your therapist will do their best to help you attain your goals. If you ever feel like it is not working between you and your therapist (and we hope you would discuss this with us), your therapist or the executive director will gladly refer you to

someone who is able to provide the appropriate services to you. Sometimes, changes made as a result of therapy may have consequences that some people consider bad, for example, a divorce. Your therapist will do their best to help everyone leave therapy with the best possible outcomes, including ending a relationship well. If therapy does not seem to be helping, your therapist will talk about alternatives for you.

Therapy sessions typically last from 30 – 60 minutes. Sessions lasting more than one hour will be billed accordingly. Your first session will last 50 – 90 minutes and the intake fee for the first session is $187.50. The fee for hourly services is $150.00 per hour unless we otherwise negotiate according to our ability-to-pay scale. In some situations, children will be scheduled for 30-minute sessions which will be billed at the rate of $75.00 per ½ hour. Payment is required at each session. Our regular fee will be charged by any professional services rendered by your therapist at your request; such as phone contacts over 10 minutes, preparation of special forms, insurance reports, and consults with other processionals, etc. For court appearances, there is a standard fee of $350.00 due prior to the court appearance. This fee covers all preparation time. If the court appearance requires more than two hours, each hour after the second hour will be billed at $150.00 per hour. Travel to court will be billed at .52 cents per mile. The travel time will be billed at normal therapy rates. There is also a charge for copying medical records of .58 cents per page for the first 250 pages and .41 cents per copy beyond 250 pages. The payment is due prior to releasing the file. You will also need to make a written request for any medical record copies. Please contact our office for the Medical Records Request Form.

If you miss an appointment without attempting to contact our office in a timely manner (generally 24 hour notice), you are still responsible for half the standard fee for that session. Your insurance will not pay for the missed appointments and you are FULLY responsible for the charges on all missed appointments.

In case of an emergency call 911 and/or go to your local emergency room. We also offer e-mail services to clients. Clients may e-mail their therapist with non-emergency and non-life threatening issues only. Your therapist(s) will try their best to return all calls and emails within one business day.

If you have any questions about your assigned therapist, the way they work, or anything else associated with therapy, please ask. Information about the licensing laws of the state of Kansas can be found at http://www.ksbsrb.org. Information about ethics in AAMFT can be found at www.aamft.org. American Association of Christian Counselors code of ethics can be found at www.aacc.net. The code of ethics for the American Association of Social Workers can be found at www.socialworkers.org

1. _____ *(Initial) I have read and agree to the terms listed on the Informed Consent Contract given to me by CFCC & Associates, Inc.*

2. _____ *(Initial) I agree to enter therapy with CFCC & Associates, Inc. and I agree to pay $150.00 per hour for each one hour session. I understand CFCC & Associates will provide a receipt for my payment. I understand that payment is due at each session and no balance will be carried unless other arrangements have been negotiated. My signature authorizes the release of information to my insurance carrier as necessary to process my claims. I understand that if my insurance does not pay for treatment that I will be responsible for the full fee.*

3. *I understand that under the provisions of KSA 65-6404(b), my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to the symptoms of a mental disorder that they may have observed while working with me or my minor child(ren). In order to complete such a consultation, my assigned therapist requests that I complete the contact information below or waive my right to have a consultation between my therapist and doctor.*

   _____(Initial) I agree to allow my therapist to contact and share relevant medical information with my doctor.

   Doctor's Name: _____

   Doctor's Address: _____

   Doctor's Phone: _____ Fax: _____

   OR

   _____(Initial) I waive my right to a consultation between my therapist and doctor.

4. *I understand that I can leave therapy at any time and that I have no moral, legal or financial obligation to complete a maximum or minimum of sessions. I am contracting to pay for scheduled therapy sessions.*

5. *I understand that I must notify CFCC & Associates, Inc. as soon as possible if it becomes necessary for me to cancel a therapy session. If I neglect to cancel a session, I may be responsible for payment of that session.*

Please check: Hispanic or Latino____ Not Hispanic or Latino_____Member declined to disclose ethnicity_____

_____ _____

Signature of Client or Legal Guardian Date

_____

Print Name of Client

_____

CFCC & Associates, Inc. – Staff/Witness Signature

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in files. The normal course of providing care means that such records may be left, at least temporarily in administrative areas such as the front office. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized with the office for the handling of charts, patient records, PHI, and other documents of information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient by the practice or requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. This practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager.
6. Your confidential information will not be used for the purposes of marketing or advertising or products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the uses of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to conform to your request.

SIGN HERE: I**, _____,** date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION AND CONSENT FORM and subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

AUTHORIZATION PAGE

Appointment Notification:

At CFCC, we will notify you of your appointment times via email, text, or phone call. Please choose one of the following options below so you can be notified. Please initial by the choice you select:

_____ I prefer to receive notifications via email at this email address:

_____

_____ I prefer to receive notifications via text message at this number:

_____

_____I prefer to receive notifications via phone message at this number:

_____

_____ _____

Print Name Signature

Client Intake Information

Person One

Name:	SSN:	Referral Source:
Gender:	Date of birth:	Education:
Relationship status: □ Never Married □ Significant Other □ Widowed □ Separated □ First Marriage □ Cohabiting □ Divorced □ Remarried		Years:
Home Address:		
City:	State:	Zip:
Home phone: _____ Leave Message? □ Yes / □ No	Cell Phone: _____ Leave Message? □ Yes / □ No	E-mail Address:
Place of Employment / School Attending:		
Work Phone: _____ Leave Message? □ Yes / □ No	Occupation / Degree working toward:	
Employment Status: □ Full-Time □ Full-time Student □ Homemaker □ Unemployed □ Part-time □ Part-time Student □ Retired		Household Income:
Medical Concerns:	Medications:	
Primary-Care Physician and Address:		
Do you have a personal relationship with Jesus Christ? □ Yes / □ No	Church Affiliation:	Do you attend? □ Yes / □ No

Person Two

Name:	SSN:	Referral Source:
Gender:	Date of birth:	Education:
Relationship status: □ Never Married □ Significant Other □ Widowed □ Separated □ First Marriage □ Cohabiting □ Divorced □ Remarried		Years:
Home Address:		
City:	State:	Zip:
Home phone: _____ Leave Message? □ Yes / □ No	Cell Phone: _____ Leave Message? □ Yes / □ No	E-mail Address:
Place of Employment / School Attending:		
Work Phone: _____ Leave Message? □ Yes / □ No	Occupation / Degree working toward:	
Employment Status: □ Full-Time □ Full-time Student □ Homemaker □ Unemployed □ Part-time □ Part-time Student □ Retired		Household Income:
Medical Concerns:	Medications:	
Primary-Care Physician and Address:		
Do you have a personal relationship with Jesus Christ? □ Yes / □ No	Church Affiliation:	Do you attend? □ Yes / □ No

Client Intake Information

Name	Relationship	Age	Occupation/Grade	Living at Home?

Emergency Contact Person

Name:	Phone #:	Relationship:

☑	Income Range	☑	Income Range	☑	Income Range
☐	$0 - $5000	☐	$20,000 - $30,000	☐	$75,000 - $100,000
☐	$5000 - $10,000	☐	$30,000 - $40,000	☐	$100,000 - $150,000
☐	$10,000 - $15,000	☐	$40,000 - $50,000	☐	$150,000 - $200,000
☐	$15,000 - $20,000	☐	$50,000 - $75,000	☐	$200,000 and Above

Counseling fees are based on ability-to-pay scale which, in turn, is determined by your annual household income, your insurance coverage, and the practitioner you are seeing. If extenuating circumstances exist and you may need to establish a payment schedule with your therapist and the financial secretary.

Insurance Information (Please provide the secretary with your card so it can be copied)

Insured's Name:		SSN:
Personal Identification #:	Group #:	Insured's Date of Birth:
Insurance Company:		Phone #:
Address:		
City:	State:	Zip:

I hereby consent and authorize to have this therapist/agency make any and all insurances claims on my/our behalf. I understand that all questions concerning insurance reimbursement and financial responsibility are to be discussed with my therapist and financial secretary.

Signature: _____ Date: _____

Signature: _____ Date: _____

Person responsible for payment and services provided:

Signature: _____ Date: _____

Client Intake Information

Adult Problem Definition

Check any recent changes you have noticed in the following areas:						
□ Vision	□ Hearing	□ Coordination	□ Balance	□ Strength	□ Speech	□ Memory
□ Energy	□ Sleeping	□ Menstrual Cycle	□ Elimination	□ Eating	□ Sexual Activity	□ Weight

Adult personal, marital, or intimate relationship concerns:
(Problems related to children should be noted on the two major categories following this section)

□ Grief/mourning following loss	□ Use of leisure time or shared activities
□ Depression/feeling blue	□ The role of men and women
□ Suicidal Thoughts	□ Domestic tasks/who does what around the house
□ Anger or difficulty controlling temper	□ Emotional abuse of/by partner
□ Loneliness	□ Physical abuse of/by partner
□ Lack of trust	□ Careers of both partners conflict
□ Feeling rejected	□ One partner is domineering/controlling
□ Low self esteem	□ We have different expectations about what marriage or an intimate relationship should be
□ High anxiety, nervousness, and/or worry	□ One or both of us no longer feel in love with the other
□ Guilt	□ One or both of us do not feel emotional support from the other
□ Midlife Crisis or difficulties related to growing older	□ One or both of us can't accept faults in spouse
□ Physical problems/illness	□ One or both of us are jealous of partner's relationships with others
□ Financial difficulties/stress	□ Other problems with friends
□ Employment difficulties/stress	□ Problems with relatives
□ Poor relations with opposite sex adults (non-marital)	□ Contact from ex-spouse or former partners upsetting our relationship
□ Alcohol or drugs	□ Relationship takes second place to the children
□ Religion	□ Abortion
□ Sexual difficulties	□ Death of parent
□ Sexual identity/sexual orientation concerns	□ Other _____
□ Value differences with relationship	
□ Poor communication	
□ Arguing or handling conflict	
□ Differences in personality	
□ Infidelity or running around	

Family Problems (This is for both adult and minors to fill out):

□ One or both of us not spending enough time with family	□ Fear of abusing child(ren)
□ Poor communication among one or more family members	□ Emotional abuse of child(ren)
□ One or more family members does/do not get along with others	□ Sexual abuse of child(ren)
□ Custody or visitation problems	□ Difficulty allowing child(ren) to grow up
□ Disagreement with partner about childrearing/discipline	□ Parents divorced
□ Not sure what to expect of children	□ Family member(s) hospitalized for mental illness
□ Don't feel I'm a good parent	□ Suicide attempt by family member(s)
□ Physical abuse of child(ren)	□ Other adjustments, please specify: _____
	_____

Client Intake Information

Child/Teen Problem Definition

Check any recent changes you have noticed in the following areas:						
□ Vision	□ Hearing	□ Coordination	□ Balance	□ Strength	□ Speech	□ Memory
□ Energy	□ Sleeping	□ Menstrual Cycle	□ Elimination	□ Eating	□ Sexual Activity	□ Weight

Child and Teen Problems:		
□ Arguing	□ Teasing	□ Mental illness/disability
□ Competitiveness	□ Temper tantrums	□ Hyper activeness (too active)
□ Complaining	□ Bossiness	□ Drugs or alcohol
□ Crying	□ Threatening	□ Sexual behavior/pregnancy
□ Talking back	□ Whining	□ Sexual identity/sexual orientation
□ Fearfulness	□ Yelling	□ Trouble with the law
□ Being bullied or bullying	□ Inappropriate attention getting	□ Misusing driving privileges
□ Masturbation	□ Destructiveness	□ Problems with dating
□ Eating issues	□ Fire setting	□ Withdrawal
□ Peer pressure	□ Not following rules or curfews	□ Difficulty in response to parent's divorce
□ Overweight/underweight	□ Running away	□ Difficulty with parents new marriage
□ Fighting	□ Stealing	□ Difficulty with divorced parents dating
□ Hitting others	□ Truancy from school	□ Difficulty with parent's sexual orientation
□ Irritableness	□ Academic problems	□ Anger/difficulty controlling temper
□ Lying	□ Poor peer relations	□ Grief/mourning following loss
□ Negativism	□ Undesirable friends	□ Poor communication
□ Noisiness	□ Bed wetting	□ Stressors/adjustments
□ Not doing chores or assignments	□ Soiling pants	
□ Sadness/unhappiness/feeling blue	□ Not eating properly	
□ Suicidal thoughts	□ Excessive worrying	
□ Suicide attempt	□ Obesity	

Looking back over all of these problems:

If you had to choose ONE problem that was the problem for which you most wanted help, it would be:

_____

Briefly explain why this problem was chosen: _____

_____