LPS Counseling, LLC

Client Information Form

Insurance Information:

Date _____

Patient Name _____ **Date of Birth** _____

Name of Parent/Guardian if Minor _____

Address _____

City/State _____ **Zip code** _____

Phone (Home)_____ **Phone (Work)**_____

Email _____ **May we leave a message?** ☐ **Yes** ☐ **No**

SS# _____ **Gender** ☐ **M** ☐ **F**

Employer _____

School (If Patient is a Student) _____

Referral Source _____

Marital Status:

☐ **Never Married** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Other**

Family Members:

Name	*Birth Date*	*Relationship*

What concern brings you to counseling?

What changes do you want to see as a result of counseling/What goals do you want to achieve?

* **Policy Holder Member Name** _____ **Holders Ph#** _____

* **Holder DOB** _____ **Holder SS#** _____
* **Address (if different from patient)** _____
* **Holder Employer Name** _____
* **Name of Insurance** _____
* **Member ID#** _____ **Group#** _____
* **Claims Address** _____ **PH#** _____

Emergency Information:

Emergency Contact _____ **PH#** _____
Relationship to Patient _____

Medical History:

Currently under doctor's care? ☐ **Yes** ☐ **No** **Date of last Physical Exam** _____

Doctor(s) involved in your care _____
Name of your Primary Care Physician _____
Address _____ **PH#** _____

Health problems (including allergies) _____

Medication currently using: (if none, state none)

Medication	Dosage	Doctor Prescribing	Reason Prescribed

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency:

Date	Reason	Hospital

Past Psychiatric History:
(Mental Health and Chemical Dependency)

Prior Outpatient Therapy - include previous practitioners, dates of treatment, previous treatment interventions, and response to treatment interventions (including responses to medications)_____
_____
_____

LPS Counseling, LLC

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours' notice to our office. For cancellations made with less than 24 hours' notice, you will be charged $50, as we are no longer able to offer that session to other clients.

Through our online scheduling system, reminders will be texted 48 hours ahead of each scheduled appointment. Please take that opportunity to confirm or cancel your session.

We appreciate your help in making the most of each client's time.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

LPS Counseling, LLC

Client Information and Acknowledgment of Informed Consent to Treatment Form

YOUR THERAPIST

Lisa Saavedra is a licensed professional counselor engaged in private practice providing mental health care services. I provide these services as a shareholder and employee of LPS Counseling LLC.

MENTAL HEALTH SERVICES

The purpose of receiving mental health care services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Lisa Saavedra, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by Lisa Saavedra.

The services I offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

APPOINTMENTS

Appointments may be scheduled through the online portal at (https://www.lpscounseling.com/OnlineBooking.en.html) or by calling (740) 953-5067. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third party payors will not cover or reimburse for missed appointments. Appointments are 50 minutes in length, but may vary for clinical reasons. The number of appointments depends on many factors and will be discussed by Lisa Saavedra with you.

RELATIONSHIP

Your relationship with Lisa Saavedra is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that Lisa Saavera not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship.

GOALS, PURPOSES, AND TECHNIQUES

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by Lisa Saavedra and to have input into setting the goals of your therapy. As therapy progresses, these goals may change. You and Lisa Saavedra will jointly determine how to effect the changes you are seeking to make for yourself.

CONFIDENTIALITY

The law protects the privacy of all communications between a client and a therapist. In most situations, LPS Counseling LLC can only release information about your treatment to others if you sign a written authorization form.

There are some situations where we are permitted or required to disclose information either with or without your consent or authorization. For example,

- **If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.**
- **If a government agency is requesting the information, we may be required to provide it.**
- **If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend the therapist.**

- **If you file a worker's compensation claim, we must, upon appropriate request, provide a copy of your records or a report of your treatment.**

There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

- **If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.**
- **If the therapist believes you present a clear and substantial danger of harm to yourself or and/or others, he or she will take protective actions. There may include contacting family members, seeking hospitalization of you, notifying any potential victim(s), and notifying the police.**

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with Lisa Saavedra any questions or concerns you may have.

PROFESSIONAL RECORDS

The laws and standards of our profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $.25 per page. If we refuse your request for access to your records, you have the right of review, which we will discuss with you upon request.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have.

AUTHORIZATION TO WARN OR INFORM THIRD PARTIES

In the event that Lisa Saavedra reasonably believes that I am a danger, physically or emotionally, to myself or another person, by signing this Client Information and Acknowledgment of Informed Consent to Treatment, I specifically consent for Lisa Saavedra to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons listed below:

NAME **TELEPHONE NUMBER**

_____

_____

_____

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization to Warn or Inform Third Parties shall expire upon the termination of my therapy with Lisa Saavedra.

I acknowledge that I have the right to revoke the above authorization to warn or inform third parties, <u>in writing,</u> at any time to the extent that Lisa Saavedra has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of

my protected health information could still be permitted by law as indicated in the copy of the Notice of Privacy Practices of Lisa Saavedra that I have received and reviewed.

AFTER-HOURS EMERGENCIES

In the event of an emergency involving threat to self or others please go directly to a hospital emergency room or call 911. Emergencies are urgent issues requiring your immediate action.

****You may use email at lisapsaavedra@gmail.com or call (740)953-5067 to schedule or cancel an appointment. However, due to the difficulty in my ability to maintain your confidentiality I will keep our exchange of information limited to dates and times of appointments scheduling or cancellations or for me to provide additional reading resources. Please remember to leave a contact phone number where you would like for me to contact you.**

LISA SAAVEDRA'S INCAPACITY OR DEATH

I acknowledge that, in the event that Lisa Saavedra becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I give my consent to allowing another licensed mental health professional selected by Lisa Saavedra to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

CONSENT TO TREATMENT

I, voluntarily agree to receive mental health assessment, care, treatment, or services, including through TeleHealth, and authorize Lisa Saavedra to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through Lisa Saavedra at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name

_____ _____

Client Signature **Date**

_____ _____

Parent or Guardian Signature (for minor child) **Date**

I may be contacted at the following:

Address: _____

City/State/Zip: _____

Telephone: _____

Email: _____

Witnessed by:

_____ _____

Date

LPS Counseling, LLC

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 information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present and future physical and mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the American Counseling Association *Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose that minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating and determining our compliance with the

requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI.

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Lisa Saavedra at 570 N. State St., Suite 230, Westerville, Ohio 43082.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice

COMPLAINTS.

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Lisa Saavedra at 570 N. State St., Suite 230, Westerville, Ohio 43082, or with the Secretary of Health and Human Services at 200 Independence Ave. SW, Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

NOTICE OF PRIVACY PRACTICES

Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of LPS Counseling LLC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lisa Saavedra at 570 N. State St., Suite 230, Westerville, Ohio 43082 or (740)953-5067.

_____

Signature of Patient/Client ***Date***

_____

Signature of Parent, Guardian, or Personal Representative* ***Date***

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

☐ ***Patient/Client Refuses to Acknowledge Receipt****:*

_____

Signature of Counselor ***Date***

LPS Counseling, LLC

Statement of Fees

Receipt, Acknowledgement of Notice, and Agreement to Pay for Services

Patient/Client Name: _____

DOB: _____

SSN: _____

Lisa Saavedra/LPS Counseling LLC charges a fee for providing services. Our standard fees for types/lengths of sessions, along with available discounts, can be found in the attached **Fee Schedule** (initial diagnostic session being $150), however managed care and insurance company contracts may have pre-set fees that we are required to accept. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your policy covers. In the event that financial restrictions are placed upon you or you do not have insurance coverage, Lisa Saavedra will provide a sliding scale fee or payment plan and encourages you to discuss this with her.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and subject to their privacy policy.

This office accepts cash, checks and all major credit cards. Please be aware that there will be a $15 return check fee in addition to any penalties incurred through the bank for non-sufficient funds.

In the event I am subpoenaed for any court proceedings, a fee of $250 per hour will be charged for all written reports, oral testimony, preparation, consultation and travel/waiting time (see **Fee Schedule** for more details). Please be aware that due to the nature of psychotherapy, confidentiality is very important and therefore, careful consideration should be given before requesting my involvement in any court proceedings as it can be to the detriment of the therapeutic process..

Client Acknowledgment

I hereby acknowledge that I am personally responsible for the fees charged for receiving services. I understand that insurance claims are submitted only as a service. I also understand that I must give 24 hour notice of cancellation (with exception for emergencies) to avoid being charged a cancellation fee for failing to attend an appointment I have made.

Signature of Client **Date**

Signature of Parent, Guardian, or Responsible Party **Date**

LPS Counseling, LLC

Fee Schedule

Please see the below schedule of charges for services provided by Lisa P. Saavedra, LPCC.
If paying via PayPal, there will be an added 2.9% fee as well as .30¢ per transaction which you must factor in.
(ie: the "Prompt and Self-Pay Discount" for a 60 minute individual session will be $72.33 via Paypal)

Service	Description	Code	Charge
Psychiatric Diagnostic Evaluation	Initial diagnostic session; typically 50-60 minutes	90791	$150.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90791	$120.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90791	$120.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90791	$90.00
Individual Psychotherapy, 60 min	Individual counseling session, 60 minutes	90837	$115.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90837	$90.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90837	$90.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90837	$70.00
Individual Psychotherapy, 45 min	Individual counseling session, 45 minutes	90834	$95.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90834	$75.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90834	$75.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90834	$55.00
Individual Psychotherapy, 30 min	Individual counseling session, 30 minutes	90832	$75.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90832	$60.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90832	$60.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90832	$45.00
Conjoint Family Psychotherapy, 50 min	Session with individual and family, 50 min	90847	$115.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90847	$90.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90847	$90.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90847	$70.00
Family Psychotherapy, 50 min	Session with family and without individual, 50 min	90846	$115.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90846	$90.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90846	$90.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90846	$70.00
Group Psychotherapy	Group counseling session, typically 50-60 min	90853	$75.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90853	$60.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90853	$60.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90853	$45.00
Crisis Psychotherapy, 60 min	Urgent counseling and related services for crisis, 60 min	90839	$150.00
♦ Prompt Pay Discount	Payment at time of session; 20% off*	90839	$120.00
♦ Self-Pay Discount	Self-payment (no insurance billing); 20% off*	90839	$120.00
♦ Prompt and Self Pay Discount	Time of session self-payment; 40% off*	90839	$90.00
Forensic Assessment and Report	Diagnostic examination, comprehensive assessment, report preparation, court testimony, and travel time, 60 min	90899	$250.00
♦ Due to nature of service and medical necessity status, forensic assessments, reports, and court testimony are not subject to prompt payment or self payment discounts			

**Discounts are rounded to nearest $5 increment. Financial Hardship and Payment Plan agreements may be available upon request*

LPS Counseling, LLC

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (insert name of client), whose Date of Birth is

_____ authorize Lisa Saavedra/ LPS Counseling LLC to disclose to and/or obtain from:

_____

The following information is to be released:

- ☐ Assessment
- ☐ Psychosocial Evaluation
- ☐ Current Treatment Update
- ☐ Discharge/Transfer Summary
- ☐ Progress in Treatment
- ☐ Other _____
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Presence/Participation in Treatment
- ☐ Continuing Care Plan
- ☐ Demographic Information

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand I have a right to revoke this authorization, in writing, at any time by sending written notification to Lisa Saavedra, 570 N. State Str., Suite 210, Westerville, Ohio 43082. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Unless sooner revoked this consent expires on the following date _____
I further understand that Lisa Saavedra/LPS Counseling LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

Lisa Saavedra/LPS Counseling LLC reserves the right to disclose information as permitted in this authorization in any manner we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42C.F.R. Part 2.

Signature of Client Date

Signature of Parent, Guardian or Personal Representative Date

☐ Check here if client refuses to sign authorization.

Signature of Witness Date

LPS Counseling, LLC

PROFESSIONAL DISCLOSURE STATEMENT

Lisa P. Saavedra, L.P.C.C.

LPS Counseling, LLC
570 North State St. Suite 230
Westerville, OH 43082

Master of Arts in Clinical Counseling
The Ohio State University, Columbus, OH
September 1999 –June 2002

Licensed Professional Counselor-Clinical Resident
License: E.0007636 Expiration: 8/20/2020

Areas of Competence:

Clinical Psychopathology, Personality, and Abnormal Behavior
Evaluation and Diagnosis of Mental and Emotional Disorders
Methods of Prevention, Intervention, and Treatment of Mental and Emotional Disorders
Human Growth and Development
Individual, Group, Marital, and Couples Dynamics, Processing and Counseling
Family, Adult and Children's Counseling
Professional, Legal, and Ethical Responsibilities
Lifestyle and Career Development
Crisis Intervention
Relaxation Skills, Assertiveness Skills, Coping Skills, Anger Management, Stress Management
Blended Family Issues

State of Ohio Counselor, Social Worker, Marriage & Family Therapy Board
50 West Broad Street, Suite 1075
Columbus, Ohio 43215-5919
Phone: 614-466-0912
Website: www.cswmft.ohio.gov

"This information is required by the Counselor and Social Worker Board, which regulates the practices of professional counseling and social work in this state."