The Kentuckiana Treatment Center for OCD & Trauma

Chris Leins, MA, NCC, LPCC-S, Clinical Supervisor

National Provider Identifier # 1821576604
Nationally (Board) **Certified Counselor** # (888133)
Delaware LPCMH # (PC-0000842)
Kentucky LPCC-S # (265384)

Please print, and carefully read through, and endorse the contents of the Signature Page; as these articulate the nature and parameters of the **Therapist-Client Services Agreement**. Federal law requires clinician-receipt of informed consent (the Signature Page) from identified consumers prior to the administration of treatment.

Completion of pages 2-10, prior to the time of your first appointment will save session-time and allow us to be more focused on the specific needs that bring you to treatment.

Any incomplete paperwork will be completed as part of your first session.

Thank you.

Signature Page

My signature below indicates that:

( ) I understand and agree that effective and successful treatment requires both my active participation in, and compliance with evidence-based treatment-protocols, and my consistency in session-attendance. Such will dramatically increase the likelihood of therapeutic success.

( ) I understand, and agree to the **Cancelation Policy** of Kentuckiana Treatment Center for Anxiety & OCD. While consistent, weekly attendance to therapy is an important element of therapeutic success, scheduled sessions do sometimes require postponements and other schedule-adjustments. I agree that, in the event of my need to cancel, or change the scheduled day/time of an appointment, I will notify Chris Leins, MA, NCC, LPCC-S **at least 24-hours prior to the beginning of the session**. A failure to do so may result in my being charged for the session as scheduled.

( ) I understand that federal law (i.e., **HIPAA**) protects my privacy, and that neither my name nor my clinical information will be shared by Chris Leins, MA, NCC, LPCC-S with outside parties and practitioners without my express, written permission. Privacy is my right. I do understand, however, that there are **limits to confidentiality**. These include my being a danger to myself or others, and the abuse of children.

( ) I understand that psychotherapy is a volunteer process and a professional transaction. And I voluntarily provide my **Consent for Therapy**, and state that I am engaging treatment-services of my own volition. Patients wishing to engage telehealth services must do so from within the boundaries of the states in which Chris Leins, MA, NCC, LPCC-S holds a license to practice professional counseling. Those states are, MN, DE, and KY.

( ) I understand that Chris Leins, MA, NCC, LPCC-S is credentialed with Deaconess Health Plans and OneCare, and therefore is able to accept Aetna, Anthem Blue Cross and Blue Shield, Cofinity, Cigna, Encore Health Network, First Health, Health Alliance, Humana Choice Care, Parkview Signature Care, and PHCS/MultiPlan in the state of KY ONLY. And I understand that **out-of-pocket expenses are due at the time of service, and that a credit card MUST be kept on file**. I further understand that I may be able to utilize **Out-of-Network Benefits** for reimbursement, should my policy include such a benefit. Should my policy include an Out-of-Network option, I understand and agree that am responsible to satisfy the therapeutic fee at the time of service.

( ) Should I have the need to pay for psychotherapy **Out-of-Pocket**, I am aware that the cost of each 60-min session is $110.00. **I agree to place a credit card on file, and understand that it will be charged at the time of service**. I am also aware that a "sliding scale," is available for patients for whom the full-fee creates hardship. Such accommodations, however, will generally not exceed a decrease of 20% of the full therapeutic.

Please be advised that you can revoke this agreement in writing at any time. That revocation cannot be retroactive and cannot prevent us from taking steps to collect if you have not satisfied any financial obligations you have incurred.

Patient Name: _____ Date of Birth: _____ Age:_____

Patient Signature:_____ Date: _____

DEMOGRAPHIC INFORMATION

Name:_____ Date of Birth: _____ Age: _____

Address:_____ City _____ State _____ Zip Code _____

Current Occupation: _____ How long? _____

CONTACT INFORMATION

Home Phone: _____ Is it ok to leave a voicemail message at that phone number? Yes No

Cell Phone: _____ Is it ok to leave a voicemail message at that phone number? Yes No

Email Address: _____ Is it ok to contact you via email? Yes No

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Best Phone: _____

Name: _____ Relationship: _____ Best Phone: _____

RELATIONSHIP AND FAMILY INFORMATION

Relationship Status: ❒ Married (since ____) ❒ Civil Union (since ____) ❒ In a relationship (since ____)
❒ Separated (since ____) ❒ Divorced (since ____) ❒ Single ❒ Widowed

Name of Spouse/Partner (if applicable): _____

Children: ❒ Yes (please indicate names and ages below) ❒ No

_____
_____
_____

Please describe your primary support: _____
_____
_____

What is the attitude of your primary support regarding treatment?
❒ N/A ❒ Willing to be involved ❒ Supportive ❒ Passively Opposed ❒ Actively Opposed

RELIGIOUS BACKGROUND

Denominational Preference: _____

Is faith/spirituality an important part of your life? _____
_____

HEALTH AND MEDICAL

Name of Primary Care Physician: _____ Phone: _____

Date of last visit _____Date of last physical _____

Do you have any current medical concerns? ❒ Yes ❒ No

If yes, please describe:

_____

_____

_____

_____

CURRENT MEDICATIONS

Medication	Dosage/Frequency	Condition	Date Started	Compliant	Effective
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No

Please list previous **psychotropic** medications (over past 3 years):

Medication	Dosage/Frequency	Condition	Date Started	Compliant	Effective
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No
_____	_____	_____	_____	Yes No	Yes No

Name of Current Psychiatrist (if applicable): _____ Phone: _____

HISTORY AND IMPACT OF PRESENT CONDITION/SYMPTOMS

What is bringing you to treatment at this time? _____

_____

_____

What are the primary symptoms you are experiencing? _____

_____

_____

When did this problem first occur? _____

_____

Were there any precipitating events to the onset of this problem?_____

_____

Please describe the impact of your symptoms/situation on current *relationships and family dynamics*: _____

_____

_____

Please describe the impact of your symptoms/situation on *friendships and/or social activities*: _____

_____

_____

Please describe the impact of your symptoms/situation on *current occupational functioning*: _____

_____

_____

If therapy is beneficial to you, how will your life be better? How will you be acting and/or thinking? _____

_____

_____

_____

SOCIAL/LEISURE

How, and with whom do you spend leisure time? _____

_____

Describe your interests and hobbies: _____

_____

Describe your strengths: _____

_____

PREVIOUS TREATMENT EXPERIENCE

If you have previously been in therapy for mental health and/or substance abuse reasons, please provide the following information: Date/s of treatment; reason/s for seeking treatment at that time; Did you find therapy effective or helpful at that time?

_____

_____

_____

_____

PSYCHOLOGICAL HISTORY

Self-injurious Behavior: Have you ever or do you currently engage in self-injurious behavior? ❒ Yes❒ No
If so, please explain (type, frequency, etc.) _____

_____

Suicidal Ideation: Have you ever, or are you currently experiencing any of the following regarding suicide?
Thoughts ❒ No ❒ Yes _____

Intent ❒ No ❒ Yes _____
Plan ❒ No ❒ Yes _____

Homicidal Ideation: Have you ever or are you currently experiencing any of the following regarding homicide? If so, please explain.

Thoughts ❒ No ❒ Yes _____
Intent ❒ No ❒ Yes _____
Plan ❒ No ❒ Yes _____

FAMILY HISTORY

Parent's Current Relationship Status:
❒ Married ❒ Civil Union ❒ Separated ❒ Divorced ❒ Reside Together

Siblings (names and ages) _____ _____

_____

How would you describe your childhood?

❒ Poor ❒ Fair ❒ Good ❒ Other

_____

Please place an "X" in the column/s of any immediate or extended biological family member/s who has or has had any of the condition listed below (include grandparents, aunts, uncles, cousins).

Condition/Relationship	Mother	Father	Sibling/s	Other (specify)
Childhood hyperactivity				
Difficulty learning to read				
Difficulty learning to write				
Difficulty learning math				
Difficulty with speech				
Repeated a grade in school				
Intellectual disability				
Developmental disability				
Neurological condition				
Depression				
Anxiety				
Drug or alcohol problems				
Legal difficulties				
Serious Illness				
Other significant difficulties				

ABUSE/NEGLECT ASSESSMENT ❒ Not Applicable

As a child or adolescent, have you ever been abused: ❒ Physically ❒ Emotionally ❒ Sexually

As an adult, have you ever been abused: ❒ Physically ❒ Emotionally ❒ Sexually

Has anyone in your family ever been violent or abusive? ❒ Yes ❒ No

If yes: who? _____ Toward whom? _____

name/relationship to you name/relationship to you

Were you the victim of neglect as a child or adolescent? ❒ Yes ❒ No If yes, please explain:

_____

_____

_____

TRAUMA HISTORY

Have you ever experienced or witnesses an extremely traumatic event that involved actual or threatened death, or serious injury to yourself or to someone else? ❒ Yes ❒ No

If you answered "Yes" to the above question, please provide details of the traumatic event/s along with any present impact this experience has on your life_____

_____

_____

_____

ACADEMIC HISTORY

Highest Level of Education Completed: _____ Year Completed: _____

Please describe any educational concerns as a child/adolescent: _____

_____

_____

EMPLOYMENT HISTORY

Are you currently employed?

Yes No

If Yes, please describe your employment pattern over the past year: ❒ Full-time ❒ Part-time (regular hours) ❒ Part-time (irregular hours) ❒ Disability ❒ Retired ❒ Unemployed ❒ Other

If Other, please explain:_____

LEGAL: Are you or do you anticipate being involved in any legal proceedings? ❒ Yes ❒ No If yes, please explain: _____

Therapy is a process that usually takes place over the course of two to six months. Patients benefit most when they adhere to treatment-protocols. While protocols vary across diagnoses, this means attending

scheduled sessions consistently and engaging psychotherapy during appointments; it means completing homework-tasks, and working to modify unhealthy behaviors. How likely is it that you will work to adhere to treatment-protocol?

1. Very likely. I am fully committed to doing whatever it takes to address my concerns.
2. Somewhat likely.
3. Possible.
4. Somewhat unlikely. I am curious but a little skeptical about the process.
5. Very unlikely. I doubt that I will attend on a weekly basis.

GENERAL WELL BEING

Over the past few weeks, how have you been doing in the following areas of your life? Score each area on a scale from 1 to 4 (1 indicating "not doing well at all" and 4 indicating "doing very well").

____ Physical well-being _____ Work, school activities ____ Emotionally

____Overall well-being _____ Close relationships

SYMPTOM CHECKLIST

Please rate the symptoms you have been experiencing in the last 2 weeks, using the following scale:

0. Does not apply
1. Mild problem- occurs once every two weeks
2. Moderate problem- occurs once a week
3. Severe problem- occurs 3 or more times per week

_____ Feeling depressed
_____ Feeling anxious
_____ Feeling overwhelmed
_____ Feeling hopeless
_____ Sleeping ❒ less than 6 hours most nights ❒ more than 10 hours most nights
_____ Loss of appetite (in past month I have lost ____ pounds)
_____ Increase in appetite (in past month I have gained ____ pounds)
_____ Panic attacks
_____ Thoughts of suicide
_____ Thoughts of homicide
_____ I have hurt myself in the last 2 weeks by: ❒ Cutting ❒ Abusing substances
_____ Having irrational thoughts or fears
_____ Engaging in compulsive behavior
_____ Feeling restless or edgy
_____ Feeling confused
_____ Having mood swings
_____ Feeling lonely
_____ Having problems in relationships
_____ Feeling irritable
_____ Feelings of unreality
_____ Feeling of being detached from oneself
_____ Tearful
_____ Excessive worrying or obsessions

_____ Nightmares
_____ Feelings of apathy or indifference
_____ Having problems sexually
_____ Isolating and avoiding interaction with others
_____ Having negative thoughts about the future
_____ Having negative thoughts about yourself
_____ Having negative thoughts about your situation
_____ Having racing thoughts
_____ Having trouble concentrating
_____ Having trouble remembering things
_____ Feeling unable to go to work, school, etc
_____ Feeling unable to keep up with family life and social life
_____ Feeling unable to keep up with household chores/responsibilities

SUBSTANCE HISTORY

Are you currently engaging in illegal drug-use, or substance-use for reasons other than prescribed for medical treatment?

Yes No

If yes, please list substances used with frequency of use._____

_____

Do you have a history of illegal drug-use or substance-abuse?

Yes No

If yes, please list substances used with frequency of use._____

_____

PAYMENT INFORMATION

1. My psychotherapy is covered under my insurance policy. Yes No
   My insurance policy is active, and is with the following company/payor: _____
   Please provide a copy (front and back) of your insurance policy-card to us, along with a credit card to be kept on file for copay only.

( ) By my endorsement below, I agree to pay my **insurance policy copay only**. My credit card information will be kept on file, and my card charged at the time of each session, or shortly thereafter.

2. I will cover the cost of my psychotherapy, **out-of-pocket**. Yes No
   Please provide a working credit card to be kept on file. This card will be charged at the time of, or shortly after services rendered.

( ) By my endorsement below, I agree to pay $110 (or the agreed-upon **out-of-pocket** therapeutic fee). My credit card information will be kept on file, and my card charged at the time of each session, or shortly thereafter.

Credit Card Number: _____ Exp. Date: _____

CVV (Security Code): _____ ZIP Code: _____

Signature: _____ Date: _____

How did you hear about Chris Leins, MA, LPCC-S, NCC and Kentuckiana Treatment Center for Anxiety & OCD?

_____ I was referred by my psychiatric or psychotherapeutic provider

_____ Word of mouth

_____ Through my own research on Google, I found KentuckyOCD.com.

_____ IOCDF.org

_____ Psychology Today

_____ Other