CREEKSIDE COUNSELING, LLC

ACKNOWLEDGMENT OF RECEIPT, REVIEW, AND UNDERSTANDING

NAME OF INDIVIDUAL:

Last	First	Middle Initial	Date of Birth

By checking the boxes below on page 1 and 2, I indicate that I have been informed of, consent to, and understand each item:

☐ **Consent to Evaluate/Treat.** I voluntarily give consent for the above named individual to participate in evaluation and/or treatment provided by Sara Grout, Licensed Master Social Worker (LMSW) license number 6867. This clinician is licensed by the Kansas Behavioral Sciences Regulatory Board to independently provide mental health diagnosis/treatment and holds a Master's Degree in Social Work.

Sara Grout, LMSW is not a physician, does not prescribe medication, and does not perform medical procedures or surgery. Please be advised certain mental disorders can have medical or biological origins. If you believe you are in need of a psychiatric or medication evaluation, please inform this clinician and referral sources can be reviewed.

☐ **Informed Consent for Treatment.** I hereby acknowledge I have received verbal explanation and have been provided the opportunity to read a copy of Creekside Counseling, LLC's ***Informed Consent for Treatment*** form. I have the right to request a paper copy of this document.

☐ **Notice of Privacy Practices Acknowledgement**. I hereby acknowledge I have received verbal explanation and have been provided the opportunity to read a copy of Creekside Counseling, LLC's ***Notice of Privacy Practices***. I understand if I have any questions regarding the Notice or my privacy rights, I can contact Sara Grout, LMSW at 785-648-5664. I have the right to request a paper copy of this document.

☐ **Client Rights and Responsibilities.** I hereby acknowledge I have received verbal explanation and have been provided the opportunity to read a copy of Creekside Counseling, LLC's ***Client Rights and Responsibilities*** form. I have the right to request a paper copy of this document.

☐ **Physician Consultation.** In Kansas, licensed mental health professionals are required to consult with a client's primary care physician or psychiatrist whenever symptoms of a mental health diagnosis are present. The purpose of such consultation is to determine if there may be a medical condition or medication that is contributing to the client's symptoms. The client/legal guardian may also choose to waive such consultation. If you do not have a primary care physician, referral sources can be reviewed with you. The clinician may provide treatment or evaluation until such time that the medical consultation is obtained or waived.

☐ I consent to consultation with my primary care physician and have signed a release of information.
☐ I waive consultation with my primary care physician.

Electronic Health Records/Electronic Insurance Claims. Creekside Counseling, LLC uses Therapy Notes for electronic medical record keeping and the clearinghouse, Change Healthcare to electronically submit insurance claims. Any information provided to Therapy Notes or Change Healthcare, either intentionally or accidentally, is strictly confidential and will be treated as such by all parties involved. Therapy Notes is HIPAA compliant. Creekside Counseling, LLC has signed a BAA with Therapy Notes.

☐ I acknowledge and authorize the business relationship (described above) between Creekside Counseling, LLC, Therapy Notes.

☐ **Assignment of Benefits.** I hereby acknowledge I have received verbal explanation and have been provided the opportunity to read a copy of Creekside Counseling, LLC's ***Insurance Information and Assignment*** form. I authorize benefits payable by my insurance contract to be paid directly to Sara Grout, LMSW/Creekside Counseling, LLC for all treatment rendered by this office/provider. I understand I am financially responsible for any charges not covered by my insurance and that total fees collected will not exceed $180.00 per initial diagnostic assessment/intake and $155.00 per hour for all other sessions. Caps set by insurance will be honored as set fee with co-payment due at time of the session. I also authorize the release of any and all information necessary for filing insurance claims and collecting fees from my insurance company. I have the right to request a paper copy of this document.

☐ **Fee Contract.** I have read and fully understand the Fee Contract for all services rendered by Creekside Counseling, LLC. I agree to promptly pay for all fees and charges for the treatment of the above named individual unless other financial arrangements are agreed upon in writing. Charges on statements are agreed to be correct unless I protest in writing within thirty (30) days of the billing date. I understand if I fail to show for a scheduled appointment without giving a 24-hour cancellation notice, I may be charged a no show fee of $25.00. I understand my services may be terminated if a second incident occurs where I fail to give proper notice to cancel a scheduled appointment. I have the right to request a paper copy of this document.

☐ **Electronic Communication.** I hereby acknowledge I have received verbal explanation and have been provided the opportunity to read a copy of Creekside Counseling, LLC's ***Authorization for Electronic Communication*** form. After being provided notice of the risks inherent in use of electronic communication, I hereby expressly authorize Sara Grout, LMSW/Creekside Counseling, LLC to communicate electronically with me, which may include the transmission of my protected health information electronically. I understand in the event I no longer wish to receive electronic communications I may revoke this authorization by providing written notice to Creekside Counseling, LLC. I have the right to request a paper copy of this document.

☐ I do not give permission for Creekside Counseling, LLC to communicate with me electronically.

☐ **I have read and fully understand the above. I have had an opportunity to ask questions regarding the services provided by Sara Grout, LMSW. I consent to the evaluation and treatment of myself or my minor child and attest I have the right to consent to treatment. I understand I have the right to ask questions of my clinician about the above information at any time. I understand any consents provided on this form expire when my case is closed at Creekside Counseling, LLC.**

_____

Client Printed Name

_____

Client Signature Date

_____

Parent/Guardian Typed Name

_____

Parent/Guardian Signature (if applicable) Date

_____

Clinician Signature Date