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Intake Forms: Services, Fees, & Payment

Services offered: Individual, family, Brainspotting, Soma-Drills, Process Group

Session length: Typically sessions are 45 minutes in length.

Family sessions, Brainspotting, and Soma-Drill sessions are typically 90 minutes in length

Through a Stabilization Phase beginning treatment, clients are typically seen 90 minutes a week.

Fees

$165 per 45 minutes. So the typical 45 minute session is $165. A 90 minute session (Brainspotting, Soma-Drills, Family Session, and more) is $330. Group is $25 per weekly group. This can be paid cash, check, or Venmo. *The preferred method is through Venmo* (www.venmo.com/RecoveryHill*) and the charge is made the morning of the session.*. Payment is expected at the time of session or prior. Checks are to be made out to Recovery Hill.

Drug testing & parent education

If enrolled for substance abuse counseling, drug testing and parent education is a mandatory component of successful outcomes for adolescents and young adults living at home.

Cancellations

All missed or canceled appointments will be billed at the usual rate if there is not a 48 hour confirmed notice. The fee for returned checks is $30.

Session starting times

Sessions will almost always start on time, give or take a few minutes. For the sake of respecting each other's time, sessions will not start after 15 minutes of being late. Please do not be more than 15 minutes late!

Additional Services

Part of the fee includes my availability via phone, email, & text outside of session. However if it is something that requires more than 10 minutes I will suggest setting up an emergency meeting. Letters for court, consultation sessions, or meetings with additional providers will have an additional charge. **Medical emergency calls should always go to 911.**

Please sign and date:

Signature: _____ Date:_____

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Important Information Regarding Confidentiality

California state law and a professional code of ethics protect the rights and welfare of those who seek therapeutic services. Essentially this means that information about clients involved in treatment remains strictly confidential. Therefore, a signed release of information form is needed prior to releasing information regarding your child.

You should be aware, however, that *the protection of confidentiality is not absolute*. There are few specific occasions, which arise rarely, when a counselor may legally or ethically be compelled to release information to another. For example, if it were the counselor's judgment that the client posed an imminent danger to himself/ herself or others, the counselor may need to notify the proper authorities or intended victim.

All therapists are required by law as mandated reporters to report any suspected child abuse or sexual molestation to Child Protective Services, any elderly abuse, are the perceived immediate threat of harm.

Finally, absolute confidentiality cannot be promised to teen clients supported by and living with their parents (as a minor who has not been emancipated) in regard to matters of overriding importance to their welfare. Such as the example if a child were a danger to self or others the therapist could not hold this information confidential.

Please be assured that everything shared is respected and handled with sensitivity as well as professional judgment. Whenever possible I will seek your full participation in any decisions that may be required.

I ask that you and/ or your child respect the privacy of others by honoring the confidentiality now and forever, of anyone, parent, or young adult that you may come in contact with while participating in the counseling process.

Please sign and date:

Signature: _____ Date:_____

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Client information sheet

Today's date: _____ Your Child's name: _____

Date of Birth: _____ Childs Phone: _____

Father's name: _____ Address: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Mother's name: _____ Address: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Step Father: _____ Address: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Step Mother: _____ Address: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Siblings name & age:_____

_____

Preferred billing address:

_____

Who referred you to me? _____

May I thank them? _____

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Authorization Release of Information

Client Information: **Authorization Date: _____**

_____

Client name DOB Telephone

_____

Address City State Zip

Authorization:

I authorize the release and/or exchange of information between:

Kenny Hill Sr. CADC III – 5150 Sunrise Blvd, Suite F4, Fair Oaks, Ca 95628 – 916.995.8635

AND

_____

Name Telephone Address

Duration:

The authorization is effective immediately and shall remain in effect for one year from authorization date.

Information to be exchanged (mark which are relevant):

____ Mutual exchange of information relevant to assessment, diagnosis, and treatment.

_X___ Billing

____ Other: _____

Authorizing Signatures:

Client: _____Date: _____

Parent/ Guardian/ Conservator _____Date: _____

Therapist: _____Date: _____

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Payment agreement

I understand that payment for services is due at the time of each session. If I or my child cannot make it to a scheduled appointment, *we must provide 48 hours notice of cancellation otherwise I will still have to pay for the missed session*. I understand that it is not acceptable for me to have an outstanding balance.

I take all financial responsibility for counseling sessions scheduled between any of my family members and our/my child regardless of whether my child is over 18 years of age.

I am keeping a credit card number on file in case there is ever a time that myself or my child may come to session without a check or a card for payment. Also, I am aware that my card on file will be charged the full amount if there is a missed session without proper notice. **I understand all sessions are non-refundable.**

Credit Card #: _____

EXP date: _____

Print name on card:

_____

Signature: _____ Date: _____

*Please note: If a loved one is providing financial support; a Release of Information must be provided for that individual. (The Release of Information form was the previous form prior to this one in the intake packet). If there is a session that is missed, or there is chronic tardiness to sessions, the financier will be notified.

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Consent to Treatment

Most people who participate in treatment benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part if you are going to get something out of it. In addition, there may be certain kinds of risks involved. For example, the therapy process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks. In fact, sometimes there can be more risks associated with not participating in therapy.

It is important that you participate in this treatment willingly. If you have any questions or concerns about this document, about the services being provided to you, or about your treatment options, you should definitely ask your therapist.

Acknowledgment

By signing your name in the space below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this treatment.

If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in the treatment.

_____

Patients/Guardian Signature (If signature other than patient, List relationship) Date

_____

Witness/ Counselor Signature Date

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Walk and Talk Waiver

I _____ understand that if walk and talk therapy occurred during a session, it is my choice to do so. If injury were to occur, Recovery Hill is not subject to litigation. I understand that with walk and talk therapy there are common hazards that can occur from walking out in public, such as (but not limited to): tripping hazards, other people in public and their actions, vehicles on the road, animals outside, ect. I understand that walk and talk therapy is a casual form of treatment that helps one get minor exercise in outside weather while also discussing possible hard topics. With this being outside in the public, I also waive any confidentiality breaches where someone may recognize me or hear pieces of what is being said in the discussion. Lastly I waive any litigation toward Recovery Hill if I were to have a situation of problematic health as a result of the minor walking-paced exercise.

Signature of client/ guardian/ conservator: Date

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Brainspotting Consent Form

I, _____, consent to using Brainspotting in my therapy at Recovery Hill. I agree to Brainspotting sessions with Kenny Hill Sr, CADC III, Certified Brainspotting Practitioner. I acknowledge that I have received brief education on the process of Brainspotting, and that the process can be a psychologically deep, emotional, and draining. Further, I agree that if I am to drive after a Brainspotting session takes place, I will remain vigilant and focused on the road – not using devices to take away my attention on the road.

Authorizing Signatures:

Consenting Client: _____ Date:_____

Parent/Guardian/Conservator: _____ Date:_____

Kenny Hill Sr, CADCIII, Certified Brainspotter: _____ Date: _____

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HIPAA

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and you're your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization. 6. Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper electronic) by a mental health professional (such as a psychologist or psychiatrist_ must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional or a group, joint, or family counseling session and that are separate from the rest of the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

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Informed Consent for Telehealth Services

This is an optional form of treatment to be used as needed. If you would like this treatment option, please sign.

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding treatment. I hereby consent to participating in psychotherapy via telephone or the internet.

I understand I have the following rights under this agreement: I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. I understand that the fee will be $165, or the same as your individual, face to face session. All information discussed within sessions is confidential, except when required by law or if required by your health insurance if you are asking them to help pay for my services. Disclosure may be legally required when: 1) there is a reasonable suspicion of child or elder abuse, 2) there is reasonable suspicion that a client presents an imminent danger of violence to others, or 3) a client is likely to harm him/herself unless protective measures are taken. If my client is an adolescent, I let the confidentiality rest between the adolescent and myself, except for mandated reporting.

I understand that while psychotherapeutic treatment has been found to be effective in treating a wide range of mental disorders, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. At the initiation of service, I acknowledge that I will be asked my full name and address of present location in case of emergency.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that therapy sessions could be altered by technical failures or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment or crisis management, I will be locally referred in my geographic area as my therapist may not be local at the time of service.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification. My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature:_____ Date:_____

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Parent/Guardian Signature:_____ Date:_____

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt? If yes enter 1 _____

2. Did a parent or other adult in the household often …
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured? If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you? If yes enter 1 _____

4. Did you often feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
If yes enter 1_____

5. Did you often feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
If yes enter 1 _____

6. Were your parents ever separated or divorced? If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
If yes enter 1 _____

10. Did a household member go to prison? If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

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Client history

Clients Name_____ Date _____

What incidents or behaviors first caused you to be concerned about the possibility that you may need therapy and/ or substance abuse counseling? (Depression, stolen money, found drugs)

_____

_____

_____

_____

Prior to coming here, what actions were taken to address the issue?

_____

_____

At this time, what problems do you attribute to chemical use?

_____

_____

Have you ever participated in any kind of counseling previously?

Name of program or counselor, From when to when, Issue, Reason for leaving

_____

_____

_____

_____

_____

Medical

Doctor's name: _____ Phone: _____

Date of last physical: _____ Current Medications: _____

_____

Childhood Illnesses:

_____

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Dates of Hospitalizations (medical and psychiatric) _____

_____

Allergies (include food): _____

Learning disabilities: _____

Supplements/ Vitamins: _____

Other helpful medical info: _____

_____

Family History

Family Medical History includes: Mom, Dad, Maternal Grandmother/ Father, Paternal Grandmother/ Father, and other family relatives.

Currently or in the past has anyone in your family ever had a problem with alcohol or drugs?

Paternal & Maternal:

_____

_____

_____

_____

Have any of them sought treatment? _____ Who? _____

_____

_____

Are any of them active in recovery? (mtgs, counseling, etc…)_____ Who? ___ _____

_____

Currently or in the past has anyone in your family used nicotine?_____

Has anyone successfully quit smoking, chewing, or vaping? _____ Who? _____

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What is your family's history with food addictions? (Bulimia, anorexia, over eating, sugar)

_____

_____

Did anyone seek treatment for their food addiction? _____ Who? _____

Who in the family has been treated for depression or anxiety?_____

_____

Has anyone in your family have a history of mental illness, diagnosed or suspected? (Manic depressive, Bi-Polar, schizophrenia, or personality disorders)

_____

_____

Has any family member been treated for mental illness?

_____

_____

Has you ever witnessed or experienced violence? (Emotional or physical)_____

Explain:_____

_____

_____

Has anyone in your family had a history of learning disorders? _____

_____

Turn over for last page

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What other information about your maternal and paternal family history do you think might be useful?

What other information about your child do you think might be useful?