Family Repair Shop LLC
Timothy L Cole, MS, LCMFT, LMFT
Licensed Clinical Marriage and Family Therapist

INFORMED CONSENT AND THERAPY CONTRACT

I feel it is important that, as my client, you are fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand my practice policies.

1. **KS and MO Licensure:** The therapist is a Licensed Clinical Marriage and Family Therapist (LCMFT 805) in Kansas and a Licensed Marital and Family Therapist (LMFT 2016019601) in Missouri.
2. **Trained in systems:** The therapist is trained to provide therapy to individuals, families and groups from a systems perspective, utilizing therapeutic approaches/models associated with the family therapy profession.
3. **Ethics:** The therapist is bound by the Code of Ethics set forth by the AAMFT.
4. **Confidentiality:** Except under specific circumstances mandated by law, communication with the therapist will remain confidential, as will any records regarding the therapy process unless you, and all other adults involved in therapy with you, give express, written permission that such information may be released.
5. **Exceptions to Confidentiality:** Under Kansas Law, specific circumstances require me to break confidentiality and report information obtained via the therapy process. Those circumstances exist when:
    a. the therapist believes a client may be a danger to him or herself or to others;
    b. the therapist believes a child, elderly, or disabled person may be subject to abuse or neglect; and
    c. when a court orders information regarding the therapy process be provided.
6. **Therapist keeps no secrets:** The therapist may meet individually or with various sub-groups among the members of the client group or family. The therapist will not keep secrets between those individuals and sub-groups. The therapist reserves the choice to disclose any information provided by a family or group member during a therapy session or via any other form of communication (phone, email, etc.).
7. **Required medical consultation:** Kansas Law requires the therapist to consult with your primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. Your guardian or you already signed a release form, that is in your main file, to authorize or decline authorization of communication between the therapist and your doctor.
8. **No subpoena of the therapist:** To involve the therapist in a domestic or CINC Court case (divorce, child custody, etc.) would constitute a dual relationship and interfere with the therapy process. I agree not to authorize an attorney to subpoena the therapist.
9. **No guarantee:** Results of therapy vary by client and are impacted by many factors. While many clients benefit and may achieve their desired results, there is no guarantee you will arrive at your hoped outcome.
10. **Cloud based storage:** The therapist has a business associates agreement with Microsoft Corporation and stores all therapy records, including yours, in cloud based encrypted storage.

My signature below indicates that I read and understand all the information on this form. I give my full informed consent to receive therapy services.

Client Signature	Date	Client Signature	Date
Client Signature	Date	Timothy Cole, LCMFT, LMFT	Date

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FINANCIAL POLICY CONTRACT

It is important to me for therapy services to be affordable for my clients. The sliding fee scale below was developed for this purpose. If you anticipate the cost of therapy may be difficult, or if it becomes problematic in the future, please bring this to my attention immediately. I would be glad to talk with you about options to address both your financial and therapy needs. You may also choose to opt out of the sliding fee scale. Please read carefully below before marking your choice. I accept cash or checks as forms of payment.

Sliding Fee Scale

Please mark the appropriate income category below to describe the gross annual income of your household. The therapy fee associated with your selection is shown in the right columns. By signing this form, you agree to pay the indicated fee at the time of service. As mentioned above, please discuss any difficulty to pay as they arise. Unless prior arrangements have been made with the therapist, failure to pay for a therapy session will pause your therapy services with Family Repair Shop LLC. In such an event, your therapist will be glad to discuss your options with you.

Annual Household Income	per 50-Minutes*	per 80-minutes*
□ 70,000 and below	$70	$105
□ 70,000 to 80,000	$80	$120
□ 80,000 and above (or opt out of income disclosure)	$90	$135

*Each therapy session includes an additional ten minutes of documentation and case management services to round out the clinical hour or 90 minutes.

Phone Therapy

You are at liberty to call your therapist at any time to discuss scheduling free of charge. Your therapist also offers therapy services by phone, pending the therapist's availability. The charge for these services is calculated as a percentage of your 50-minute fee (above). Phone therapy is organized in 15-minute increments. If your therapist is not available to answer your call, please leave a brief message regarding your needs. Your therapist will call you back within 24 hours. Phone therapy charges are due at your next appointment. See details below:

0 - 5 min.* = 25% fee	5 - 20 min.* = 50% fee	20 - 35 min.* = 75% fee	35 - 50 min.* = fee

* Time above refers to talk time. Fees pay for an additional 10 minutes of documentation and case management time to equal 15-minute increments.

Cancellations and No-Show Appointments

Please provide 24 hours notice when canceling appointments. Cancellations with less than 24 hours notice and no-show appointments will incur a fee equal to 50% of your 50-minute fee (above). Your therapist understands the unexpected may happen and people forget appointments. Your therapist will offer two 'free' last minute cancellations or one no-show appointment, per year of treatment, prior to applying the fee.

My signature below indicates I have read this Financial Policy Contract, provided accurate information and agree to abide by the fee arrangements indicated above. I understand this agreement may be amended with an updated form, should my income situation or preference to participate in the sliding fee scale change in the future.

_____		_____	
Client Signature	Date	Client Signature	Date
_____		_____	
Client Signature	Date	Timothy Cole, LCMFT	Date

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MINOR CONSENT

This is to certify that I/we, (please print) _____ and _____ have legal custody or guardianship of the following child(ren) and have the legal right to authorize the care, treatment and counsel of this/these child(ren):

Name of Child	Date of Birth

and give consent for him/her/them to receive individual and/or family therapy from Timothy Cole, LCMFT.

_____ _____
Legal Custodial Parent/Guardian Signature Date Legal Custodial Parent/Guardian Signature Date

_____
Timothy Cole, LCMFT Date

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COORDINATION OF CARE AUTHORIZATION AND RELEASE OF INFORMATION

Under Kansas Law, your therapist is required to consult with your primary care physician or psychiatrist to determine if a medical condition or medication may be contributing to symptoms of a mental disorder. It is your choice whether or not to authorize this coordination of care and release the information to be exchanged between your therapist and doctor(s). Your consent will last for one year, unless you revoke your consent in writing. Please indicate your wishes by selecting one of the three choices below:

Client name (printed) _____ Date of birth _____

□ I want Timothy Cole, LCMFT to notify my physician that I have initiated mental health services and I am willing to provide contact information for my physician below:

Physician name: _____

Address: _____

Telephone #: _____ Fax #: _____

or

□ I do not want Timothy Cole, LCMFT to notify my physician that I have begun mental health services. Skip the rest of this form and sign below.

or

□ I do not have a primary care physician. Skip the rest of this form and sign below.

Clinical Information to be Released to the Physician (for therapist use only)

Dear Dr. _____:

The above named client was initially seen: _____

The following provisional diagnosis was assigned: _____

Coordination of care issues and other significant information impacting medical or behavioral health care: _____

_____

_____

_____ _____
Timothy Cole, LCMFT Date

_____ _____ _____ _____
Client/guardian signature Date Timothy Cole, LCMFT Date

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THERAPY INTAKE ASSESSMENT FORM

FAMILY INFORMATION

Name	Date of Birth	Today's Date
Address	Home Phone	Cell Phone
Spouse's Name	Date of Birth	Home Phone
Address	Home Phone	Cell Phone

Please list additional family members or friends living with you:

Name	Relationship	Date of Birth

PSYCHOSOCIAL AND MEDICAL HISTORY

1. Have you participated in therapy services before? □ Yes □ No If yes, briefly describe:_____
   _____
2. When was your last physical?_____
3. Have you ever had a head injury resulting in the loss of consciousness? □ Yes □ No If yes, please explain:_____
   _____
4. Please list any ongoing or intermittent medical issues:_____
5. Have you ever seen a physician for mental health issues? □ Yes □ No If yes, please explain:_____
   _____
6. Have you ever been hospitalized for mental health reasons? □ Yes □ No If yes, please explain:_____
   _____
7. Have you ever heard or seen things others people could not hear or see? □ Yes □ No If yes, please explain:_____
   _____
8. Please mark appropriately below and list the specific medications that you have taken or currently take:
   I have taken antidepressants □ never, □ previously, □ currently:_____
   I have taken antianxieties □ never, □ previously, □ currently:_____
   I have taken antipsychotics □ never, □ previously, □ currently:_____
   I currently take these other prescription drugs:_____
   _____
9. Have you ever been arrested? □ Yes □ No If yes, for what?_____
   _____
10. Are you currently involved or do you expect to be involved in any court-related matters? □ Yes □ No If yes, please explain:_____
    _____
11. Please describe any illegal drug use history:_____
    _____

12. Have you, or anyone in your immediate family, ever been physically, sexually, or emotionally abused? □ Yes □ No If yes, please summarize:_____

_____

13. Are you currently suicidal? □ Yes □ No Have you ever attempted suicide? □ Yes □ No If yes, briefly describe:_____

_____

_____

14. Do you have any concerns about drug or alcohol abuse in your family? □ Yes □ No If yes, briefly describe:_____

_____

_____

15. Do you have any concerns about violence or abuse in your family? □ Yes □ No If yes, briefly describe:_____

_____

_____

16. Have you or are you currently contemplating or participating in an affair? □ Yes □ No If yes, please explain:_____

_____

_____

17. Please describe the three most important:

People in your life:_____

_____

_____

_____

_____

_____

Events of your life:_____

_____

_____

_____

_____

_____

Decisions of your life:_____

_____

_____

_____

_____

_____

18. What is it you hope your therapist can help you accomplish through therapy services?_____

_____

_____

19. What cultural, spiritual or religious resources do you have to assist you to accomplish your goals?_____

_____

20. Is there anything else that you would like your marriage and family therapist to know during this initial assessment?_____

_____

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AUTHORIZATION & REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION AND PRIVILEGED COMMUNICATION

In accord with my legal right to confidentiality and privileged communication relevant to the services I have received, I authorize and request the disclosure of confidential information ***from/to*** _____ ***from/to Timothy L Cole, LCMFT***.

The client(s) will indicate and initial their choice(s) of release listed below:

_____ a. summary report of services received
_____ b. consultation and/or verbal communication between the above named parties
_____ c. any and all records pertaining to services received
_____ d. other (please specify) _____

It is my understanding that this information will be used for _____

_____

This consent expires _____, unless revoked by me in writing at an earlier time. If left blank, this consent expires one year from the date signed below.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

In accordance with federal regulations (42 CFR Part 2) which prohibit any further disclosure of this information, except with specific written consent of the person to whom it pertains, redisclosure of this information is prohibited.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication.

I understand that the person(s) named as following (printed below) participated in the therapy and must sign this request for release, before any information in the file may be released:

Client(s) or parent and/or legal guardian's printed name(s), signature(s) and date:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

Timothy Cole, LCMFT Date

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NOTICE OF PRIVACY PRACTICES

This notice is effective 6/21/17, and describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** If you have questions, please contact the privacy officer Timothy Cole at therapist@familyrepairshop.com or 913-747-4960.

Your Choices

This section explains your rights related to your health information and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (i.e., home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. We will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

How do we typically use or share your health information?

We typically use or share your health information in the following ways. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will be available upon request, in our office, and on our web site.