

Frankfort Office
80 C. Michael Davenport Blvd.
Suite A
Frankfort, KY 40601
Office 502.352.2208
Fax 502.352.2209
www.ezcounseling.com



Hello and thank you for allowing us to assist you.

It is with great pleasure that we welcome you to our clinical practice. Our hope is to serve you and or your family and work toward the best possible outcome you desire. Our clinicians are professionals with the highest of standards for your care.

You have several rights as a patient. These include the right to know fees, ask questions and to end services at any time. The paper work which follows will also inform you of the limits of confidentiality and how your personal health information is used.

The following paperwork must be completed in its entirety for the assessment and following therapy sessions to take place. Your information is confidential within the limits described on the following pages. Keeping your privacy is something we take very seriously. If you need assistance completing some of the questions, we will gladly assist you at your first session. We can assume no responsibility for your case until our first session in person occurs, which we look forward to.

Again, thank you kindly for selecting our practice. We look forward to providing the professional services you expect.

Sincerely,

Paul D. Dalton, MS, LPCC, CADC

For detailed information, please visit our website-www.ezcounseling.com

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Informed Consent & Permission for Treatment

Your information, including your status as our client is kept strictly confidential. We respect your legal right to confidentiality and will protect your information with the proper care. Identifying information will not be released without your permission. All records will be maintained in a confidential manner. Consent forms will be required for the release of any information. State and Federal laws may require the release of information without written or verbal consent in the following specific situations:

1. Medical or Mental Health Emergencies
2. Clients become a danger to themselves (Suicidal thoughts/behaviors/attempts, severe depression, etc.)
3. Clients become a danger to others (Homicidal thoughts/behaviors/attempts) ** The person threatened and the police will be notified.
4. Any report or suspected child abuse or neglect (Physical or sexual).
5. Any report or suspected domestic violence.
6. A court order directing the release of information.
7. Any litigation initiated by the client related to treatment.
8. Any abuse of the elderly, with mental illness or who cannot care for themselves properly.

Fees are due at the time of service delivery. Prices may be reduced for shorter time periods. Cash and Check are accepted forms of payment. Clients are responsible for payment of delivered services. We will make an attempt to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility including, but not limited to: deductibles, co pays, and any other fees not covered by your insurance provider. Assessment fees are not covered by insurance in most cases.

I consent to release any personal or clinical information required to process my claim to my insurance provider or my EAP provider. I also authorize any payments made by my insurance company or EAP provider to be paid directly to Paul D. Dalton, MS, LPCC, CADC. This form will be considered a signature on file for all future insurance claims. I understand that Paul D. Dalton, MS, LPCC, CADC is a Professional Limited Liability Company and not the individual Paul D. Dalton.

I understand and agree to the limits of confidentiality as indicated above. I agree to hold and the offices of Paul D. Dalton, MS, LPCC, CADC, and any contracted therapist harmless for any loss, cost or damages sustained by my spouse, child or me. By signing this form, I hereby authorize the offices of Paul D. Dalton, MS, LPCC, CADC to assess, diagnose and treat mental health and or substance abuse problems for myself, my family and or my child.

I acknowledge that I have received a copy of the privacy practices and that I understand them.

Client Name-Printed

SS# of client

DOB

Client Signature

Parent Signature for minors under 18

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Fee Agreement

| <u>Service Type</u> | <u>Charge</u> |
|--|---|
| Individual Assessment 45-50 minutes | \$125.00 |
| Individual Session-45 minutes | \$100.00 |
| Family Session-45 minutes | \$125.00 |
| Marital Therapy-50-55 minutes | \$125.00 We do not accept insurance for Marital Therapy. |
| Returned Check Fee | \$40.00 minimum |
| Fail To Keep Appointment | \$75.00 minimum |
| Substance Abuse Assessment Tools | \$75-\$225 Testing Fee |
| ADHD Assessment Regular Fees Plus | \$75 Testing Fee |
| Deposition | \$250 plus \$125 per hour |
| Court Appearance | \$500 plus \$125 per hour |
| DOT SAP ASSESSEMENT | \$450.00 minimum |
| <i>Any matter in which we must hire an attorney to assist or protect our office involving your case, the case of a minor or a related case and any action brought upon our office by any attorney for any reason related to your case.</i> | <i>All attorney's fees billed to us by our attorney, plus any regular fees that we charge.</i> |
| Medical Records | \$2 per page after free copy |
| Letters, Phone Calls, Responding to Emails, Reviewing Testing, or Any Work related to your case not covered in a session or fee as described above | \$100 per hour billed in \$25 increments for ¼ of an hour minimum. |
| <p>Any and all work our office does on your part will be discussed prior to performing the service. By signing this form, you agree that all fees not paid by your insurance will be your responsibility. All bills not paid within 60 days will accrue a 5% interest charge and will likely be turned over to a collection agency. We will always bill you first and hope to work out any payments necessary. You also agree to allow any fees not paid to be billed to your credit card on file. By signing this form I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed. Any cancellations or changes to appointment times must be made with at least a 24 hour notice. Failing to keep an appointment or canceling with less than 24 hours notice will result in a \$75 fee.</p> | |
| Client Signature _____ Date _____ | |
| Patient if a minor _____ | |

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Credit Card Authorization Form

This form is required by all of our clients. Exceptions must be approved or prepayments must be made. Our primary goal is to take care of all expenses at the time of services.

We keep a copy in your confidential record for the reasons below.

1. To bill any **unpaid charges** that may accrue as a result of having a deductible, co-payment, or Coinsurance and or any other fees agreed upon that were not paid at the time of service delivery. Also to collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program or managed care company.
2. To bill any **Fail to Keep Appointment Fees or Cancellation Fees that are not paid by you through regular contact or billing.**
3. Any NSF or Returned Unpaid Check amount plus returned check fees from your bank.

By providing the information below you agree to allow our offices to bill the above mentioned fees and any other agreed upon fees located in the Informed Consent or Fee Schedule not paid by you in person or by regular billing. You also agree that all NSF or unpaid checks will be charged an extra \$40.00 charge. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card.

Name exactly as it appears on card _____

Type of Card (Visa and MC ONLY) **Visa MC**

Card Number _____

Expiration Date **Month**_____ **Year**_____

Security Number (3 digits back of card) _____

Billing address for card Same as home address? **Yes No** (If no fill in below)

Phone number for card Same as **Home Phone Cell Phone**
Other _____

Client or Parent Signature _____

Date _____

Thank you.

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Release of Confidential Information

I _____ authorize the offices of Paul D. Dalton, MS, LPCC, CADC to **Release** and **Obtain** the following types of information regarding my mental health / substance abuse treatment or a minor's treatment _____ of which I am the guardian. This release expires one year from the date of our last appointment or _____.

Please release my protected health information to ___ and or obtain from ___ the following entity:
Type of information: Assessment/Diagnosis Discharge Summary Treatment Plan Progress Notes
Verbal Collaboration Entire Chart Other _____

1 _____
Name Address

City State Zip Telephone Number

Purpose 1 _____

Please release my protected health information to ___ and or obtain from ___ the following entity:
Type of information: Assessment/Diagnosis Discharge Summary Treatment Plan Progress Notes
Verbal Collaboration Entire Chart Other _____

2 _____
Name Address

City State Zip Telephone Number

Purpose 2 _____

Please release my protected health information to ___ and or obtain from ___ the following entity:

Type of information: Assessment/Diagnosis Discharge Summary Treatment Plan Progress Notes
Verbal Collaboration Entire Chart Other _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature Date SS#

Parent/Guardian Signature Date SS#

Witness Signature Date

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Client Information

This information is required before any services are rendered.

| | | |
|-----------------------------|-----------------|-------------------|
| _____ | _____ | _____ |
| Full Name | SS # | DOB |
| _____ | _____ | _____ |
| Address | City | ST. Zip |
| _____ | _____ | _____ |
| Home Phone Number | Cell Phone | Emergency Contact |
| _____ | _____ | _____ |
| Parents Names If Adol/Child | Work Phone | Emergency Number |
| _____ | _____ | _____ |
| Insurance Subscriber * | Subscriber ID # | Subscriber DOB |
| _____ | _____ | _____ |

* Subscriber is the individual whose insurance is providing the coverage

| | | |
|---------------------|--------------|----------------|
| _____ | _____ | _____ |
| Subscriber Employer | Group Number | Effective Date |

| | |
|---|------------------------------------|
| _____ | _____ |
| Insurance Company/EAP Name** | Phone # for Mental Health Benefits |
| <i>**Your mental health benefits may be administered by a different company than your card reflects</i> | |

| | | | | |
|---|--------------------------------------|-----------------------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| Insurance Company Claims Address | City | State | Zip | |
| Have you preauthorized this visit? Yes No | Is preauthorization required? Yes No | | | |
| Is this an EAP referral/visit? | Yes No | Authorization # _____ | | |
| Do you have an authorization number? | Yes No | Authorization # _____ | | |

List the number authorized _____

| | | | |
|---|-----|----|--------------|
| Deductible for mental health/substance abuse care?*** | Yes | No | Amount _____ |
|---|-----|----|--------------|

***Note that medical and mental health deductibles may differ and or be calculated separate

Has the deductible been met? Yes No NA If not, the deductible will be charged until met.

Does your plan include a co-payment or coinsurance? Amount or percent _____

Are your sessions limited or unlimited? (circle one) # of sessions per year if limited _____

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Presenting Problem

How did you hear about us? Insurance Company Phone Book EAP
Friend/Relative Website Other Provider
Other-please list _____

Please describe in detail the symptoms of the problem (who, what, when, where, how, why)

What do you believe may contribute to the problem? List specific behaviors, thoughts, feelings or attitudes contributing to the problem

What has worked in the past to assist with this problem?

What have you tried that has not worked?

Do you have any family members or extended family members with a history of any type of mental illness or substance abuse problems, that take medications to improve their mental health condition, or have been to a psychiatrist, mental health professional, psychiatric hospital or alcohol/drug treatment program? Please list immediate and extended family members. Please give details. Use back if necessary.

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List all previous mental health or substance treatment or counseling with dates and names of providers including all hospitalizations with dates and providers

Have you ever thought about harming yourself in anyway? Yes No
If yes please list the details, including dates and circumstances:

Do you feel like harming yourself now or in the near future Yes No
Do you feel like harming someone else right now? Yes No
If yes please list the details, including dates and circumstances:

Please list all drugs you use or have used, including caffeine, alcohol and nicotine, any illegal drugs, prescription medication, the amounts, frequency and when you first began to use them and what your use has been like in the last year.

If you now see or have been to a psychiatrist, medical doctor or therapist for this or a related mental health or medical problem please list the name, address and telephone number of the health professional on the release of information form.

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Privacy Practices information for the offices of: Paul D. Dalton, MS, LPCC, CADC & Substance Abuse Professionals of KY, PLLC, 501 Darby Creek Road, Suite #11, Lexington, KY 40509, and all other addresses. Phone 859.338.0466

Effective April 14, 2003

This notice describes how health related information about you may be used and disclosed and how you can access this information. This notice applies to all of the records of your care generated by our office whether created by our office or an associated facility. This notice describes our practices policies which extend to: All employees, staff and other personnel that work for or with our practice (billing clerk, etc.). All office areas (front desk, waiting area, etc.); Our business associates (billing service, clearinghouse, covering therapists, etc.)

We are required by law to:

Make sure that medical information that identifies you is kept private, except in certain situations where we are allowed to disclose information under the protection or direction of state or federal law. Give you this notice of our legal duties and privacy practices with respect to medical information about you. Follow the terms of this notice now in effect.

Responsibilities:

Maintain the privacy of your health information as required by law, provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you, abide by the terms of this notice and notify you if we cannot accommodate a requested restriction or request. Accommodate your reasonable requests regarding methods to communicate health information with you. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our office containing the effective date. In addition, each time you visit our office for treatment, you may obtain a copy of the current notice in effect upon request. We will not use or disclose your health information without your authorization except as described in this notice or in situations that can be reasonably inferred from the intended uses listed in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Patient Health Information Rights:

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:

Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
Request that you be allowed to inspect and copy your health record and billing record— you may exercise this right by delivering the request in writing to our office;
File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
Revoke authorizations that you made previously to use or disclose information except to the extent of information or action has already been taken by a written revocation to our office.

With your consent, the practice is permitted by federal privacy laws to make use and disclosure of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, assessment and test results, diagnoses, treatment and future care or treatment. You have a right to review this notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment and health care operations purposes.

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How we use and disclose health information:

For Treatment: We may use your health related information to you to provide initial, ongoing or referral services for you. This may mean discussing your case or collecting records from a previous provider or disclosing your records to collaborate with a previous, current or future provider, such as psychiatrists, psychiatric hospitals and or doctors or other healthcare professionals. If you are a minor certain healthcare information may be disclosed to your parents or guardian during treatment.

For Payment: We may use and disclose health related information in billing and insurance operations needed to collect payment for the services you have received. This information may be shared with your insurance or managed care company and will be viewed by our billing department. You may receive a bill at your address for services rendered. Your healthcare plan may require ongoing and updated detailed information of your treatment in order to provide payment as permitted by KY and USA laws. Individuals involved in your care or in payment of your care may also be informed of your healthcare.

For Healthcare Operations: We may use or disclose information about you for practice operations. These uses and disclosures are necessary to run the operations efficiently and increase the quality of care we provide. For example, we may use your healthcare information to review our treatment and service and to evaluate our performance of our staff in providing your care. We may also use this information to determine the need for new services and to train students, billing personnel and other employees of the practice. We may remove data that identifies you personally before others view it or use it to study healthcare delivery without identifying patients.

Appointment Reminders: We may send reminders in the mail or leave phone messages both or which could be intercepted by others. If you do not wish for us to leave messages please indicate this with your therapist or counselor. **Emergency Situations:** We may disclose medical information about you to an organization assisting with an emergency medical or mental health condition or crisis so that you may receive the proper health care and or so that your family can be notified about your condition. **Law Enforcement:** We may release healthcare information if asked to do so by a law enforcement official in response to a court order, to protect and individual or yourself from imminent harm or danger, in emergency situations to report a crime or in the process of facilitating a transfer to a hospital of any kind. **Department of Community Based Services:** We may disclose healthcare as required by KY law in order to report suspected child abuse or domestic violence of any kind.

Judicial/Administrative Proceedings, Probations Officers, Court designated Workers, Parole offices and Judges: Healthcare information may be disclosed to these individuals with a written consent to do so. We disclose detailed information including date and time of appointments, clinical progress and treatment compliance as well as other information requested and listed on the consent.

To Report a Problem please notify Paul Dalton @ 859.338.0466

If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave, SW, Washington, D.C. 20201 or email to www.hhs.gov. There will be no retaliation for filing a complaint. The address for OCR is listed as follows

Office for Civil Rights:

U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F, HHH Building
Washington, D.C. 20201

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment.

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Our address is: 80 C. Michael Davenport Blvd. (Prevention Park)
Frankfort, KY 40601
Phone is 502.352.2208

- Please be advised we will be in session and likely not be able to answer if you are lost.
- From US 127, turn on to Kings Daughter Drive.
- At the traffic light turn right onto Doctors Drive.
- Continue to stop sign in front of Western Hills High School.
- Go straight through the stop sign into Prevention Park.
- At the second stop sign turn right (across from YMCA, not the YMCA youth association).
- Take the first drive on your right.
- We are the first double doors on the left next door to the Diet Center, Suite A.

