

501 Darby Creek Road, Suite 11
Lexington, KY 40509
(859) 338-0466
paul@ezcounseling.com

80 C. Michael Davenport Blvd.,
Suite A
Frankfort, KY 40601
(502) 352-2208
lbestfcs@aol.com



5011 Atwood Drive
Richmond, KY 40475
(859) 314-1281
carrie@ezcounseling.com

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.

We do have a secure online email system you may use. We do apologize in advance for not being able to communicate by regular email or text message, as these are not protected forms of communicating with you under privacy laws.

You will not need all the pages that follow. Please print out only the ones you need.

Again, thank you kindly for selecting our practice. We look forward to providing the professional services you expect. If at any time you would like to recognize one of our clinicians or have an issue that needs my attention, please contact me directly at our Lexington office.

Sincerely,

Paul D. Dalton, MS, LPCC, CADC

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



New Client Intake Paperwork

This information is required before any services are rendered

You may complete this section at <http://www.therapyappointment.com/>. We encourage you to do so. You may also fill in the appropriate sections, print out and bring with you or complete in written format.

Patient's Last Name:	
Patient's First Name:	
Patient's Middle Initial:	
Patient Goes By (if other than above):	
Date of Birth (mm/dd/yyyy):	
Patient/Responsible Party Social Sec. #	
Patient's Gender:	Female or Male
Patient's Marital Status:	Single Married Other
Patient's Employment Status:	Employed FT Student PT Student Other
When did current symptoms appear (mm/dd/yyyy)?	
First date of same/similar illness (mm/dd/yyyy)?	
Related to accident or workers comp?	No Yes Explain_____
The following information is needed to use our secure email system. This will help you schedule and cancel appointments via internet, receive appointment reminders and more. Thank you!	
Patient's Email address:	
Login Name: (6 letters/numbers)	
Password: (6 letters/numbers)	
Address line 1:	
City:	
State:	
Zip Code:	
Home Phone Number:	
Second Home Phone (optional):	
Work Phone Number:	
Work Extension:	
Cell Phone Number:	
Cell Phone Carrier:	AllTel AT&T Boost Nextel Sprint SunCom T-Mobile Verizon VoiceStream Virgin Cricket U.S. Cellular Metro PCS Qwest ACS Other
If other please list:_____	
Second Cell Phone Number (optional):	
Other Responsible Party (who is financially responsible?):	
Responsible Party Street Address:	
Responsible Party City, State, and Zip:	
Patient Status:	New Active Inactive
What kind of appointment reminders?	Email (requires email address) Text Message (requires cell phone and carrier) Phone call (requires home phone number) None (no reminder will be sent)

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If insurance will be used please fill in this section.

Primary Insurance Company:	
Insurance I.D. Number:	
Insurance Group Number:	
Effective Date (mm/dd/yyyy):	
Referring Physician (rarely needed):	
Referring physician NPI (Tricare only):	
Patient's relationship to Insured:	Self Spouse Child Other
Insured Name (Last, First MI): <i>* Subscriber is the individual whose insurance is providing the coverage</i>	
Insured's Street Address:	
Insured's City:	
Insured's State:	
Insured's Zip Code:	
Insured's Phone # (with dashes):	
Insured's Date of Birth (mm/dd/yyyy):	
Insured's Gender:	Female Male
Insured's Employer: <i>**Your mental health benefits may be administered by a different company than your card reflects</i>	
Phone # for Mental Health Benefits	
Insurance Company Claims Street Address, City, State, Zip:	
Deductible Amount: \$ <i>***Note that medical and mental health deductibles may differ and or be calculated separate</i>	
Deductible Amount Met: \$ (If not, the deductible will be charged until met)	
Required to pay at:	
Copay Amount: \$	
Visit Limit ?(unlimited=999):	
Is this an EAP referral/visit?	Yes No
Preauthorization required for Mental Health?	Yes No
Authorization Number:	

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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 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/S.A.P KY PLLC. This form will be considered a signature on file for all future insurance claims. I understand that Paul D. Dalton, MS, LPCC, CADC/ S.A.P KY PLLC 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 any clinician working under contract and the offices of Paul D. Dalton, MS, LPCC, CADC/S.A.P KY PLLC, harmless for any loss, cost and or damages sustained by my spouse, child or me. By signing this form, I hereby authorize all contracted clinicians of Paul D. Dalton, MS, LPCC, CADC/S.A.P KY PLLC 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

Service Type	Charge
Individual Assessment 45-50 minutes	\$125.00-\$175.00 (Psychiatric \$175)
Individual Session-45 minutes	\$100.00
Family Session-45 minutes	\$125.00
Marital Therapy-50-55 minutes	\$125.00
Medication Management 20 minutes	\$80.00
Returned Check Fee	\$50.00 minimum
Fail To Keep Appointment	\$75.00 minimum
Cancellation Without 24 Hour Notice	\$75.00
Substance Abuse Assessment Tools	\$75-\$225 Testing Fee
ADHD Assessment Regular Fees Plus	\$50-\$125 Testing Fee
Deposition	\$250 plus \$200 per hour
Substance Abuse Evaluation-Non DOT	\$225-\$275 (Nursing Eval. \$275)
DOT SAP ASSESSEMENT	\$450.00 minimum
Court Appearance	\$500 plus \$175 per hour
<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 attorneys' fees billed to us by our attorney, plus any regular fees that we charge.</i>
Medical Records	\$1 per page after free copy
Letters, phone calls, reviewing testing, or any work related to your case not covered in a session.	\$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, I agree that all fees not paid by my insurance will be my responsibility. All bills not paid within 60 days will accrue a 5% interest charge and will likely be turned over to a collection agency. I also agree to allow any fees not paid to be billed to my 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 notices. Failing to keep an appointment or canceling with less than 24 hours notice will result in a \$75 fee.</p>	
Client Signature _____	Date _____
Parent if a minor _____	Date _____

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Credit Card Authorization Form

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE.

Your information is confidential and protected by federal and state privacy laws. This form is not intended for primary method of payment. **Our office prefers cash or check.** Our primary goal is to have expenses paid 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.**
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** _____

CCV/Security Number (3 digits on 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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HIPAA Privacy Authorization Form/Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

This is a voluntary form used by our office to collect or release information that may be used to improve or communicate your treatment here. If you have more than one practitioner, please complete the form for each practitioner. Thank you.

1. I hereby authorize: Paul D. Dalton, MS, LPCC, CADC/SAP, KY, PLLC

or _____

Name, address, phone & fax # of Individual or Health Care Provider disclosing/releasing information

To release my protected health information described below to: Paul D. Dalton, MS, LPCC, CADC/SAP, KY, PLLC or

Name, address, phone & fax # of Individual or Health Care Provider receiving information

2. Authorization for Release of Information. Covering the period of health care from: all past, present and future periods

OR _____ to _____

a. I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. I hereby authorize the release of my complete health record with the exception of the following information:

Mental health records Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment

Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment, mental health treatment, substance abuse treatment, or consultation for treatment, assessment and recommendation, billing, claims payment, referral from or to another agency, or other purposes as I may direct which include:

4. This authorization shall be in force and effect until 1 year from my last appointment or _____, at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Client Signature

Date

SS#

Parent/Guardian Signature

Date

SS#

Witness Signature

Date

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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

Provider/Hospital

Dates of Service

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:

Current prescription medication types, dosage and date of first use:

Drugs/Alcohol

Illegal Drugs-List types, amounts and frequency

Alcohol- List types, amounts and frequency

Nicotine- List types, amounts and frequency

Caffeine- List types, amounts and frequency

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, CRC, CADC & Substance Abuse Professionals of KY, PLLC, 501 Darby Creek Road, Suite #11, Lexington, KY 40509, and 80 C. Michael Davenport Blvd, Suite A Frankfort, KY 40601, 859.338.0466 & 5011 Atwood Drive, Richmond, KY 40475, 859.314.1281
Effective May 25, 2011

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, therapists, 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. The owners of the practice, management, and or clinical supervisors may collaborate with your clinician(s) and review your information for supervision purposes. 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, EAP, and 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, by text, 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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Directions may also be obtained from our website: <http://www.ezcounseling.com/directionslex.html>

Directions to our LEXINGTON OFFICE:

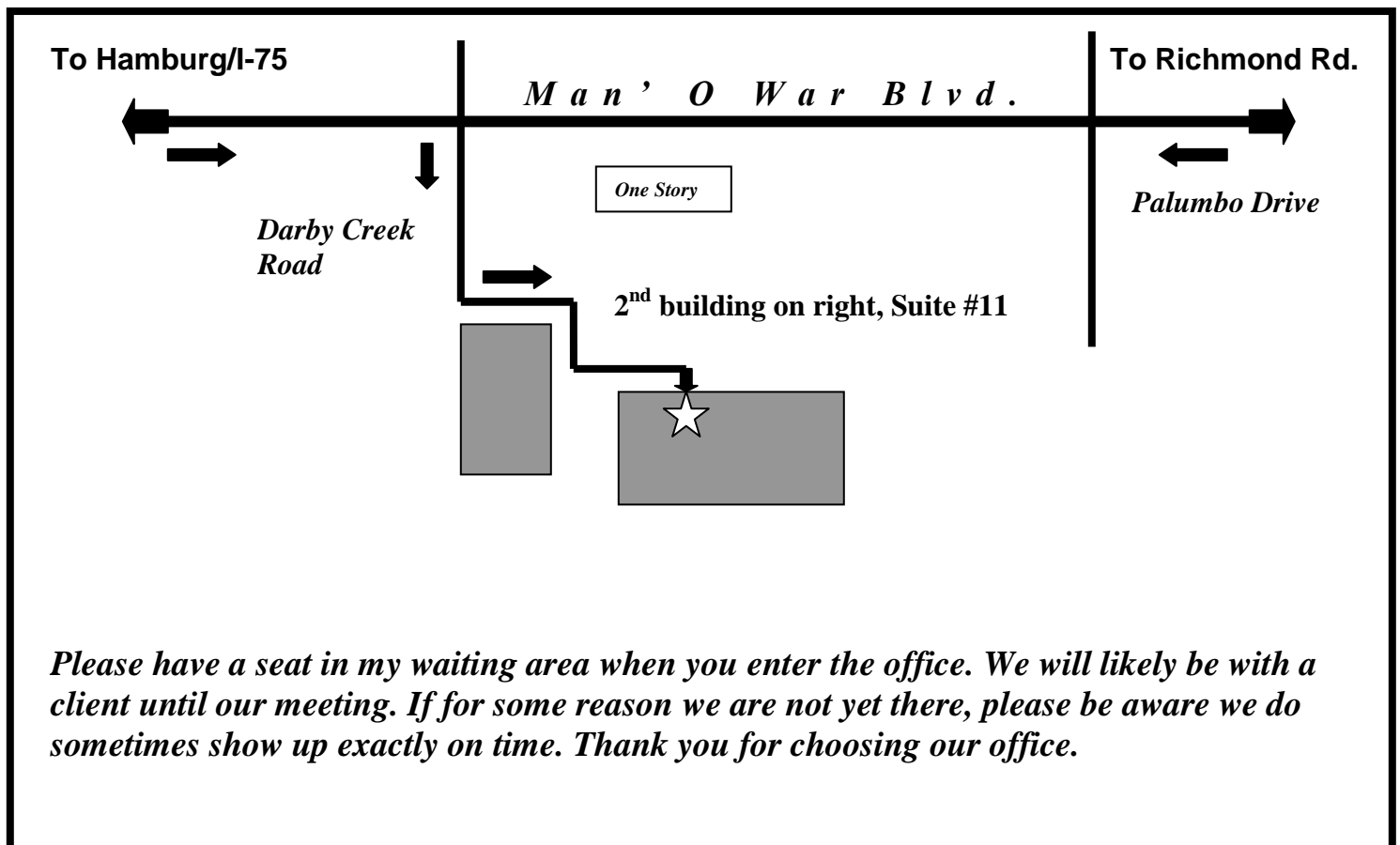
Our address is :501 Darby Creek Road #11, Lexington, KY 40509 Phone 859.338.0466

Please be advised we will be in session and likely not be able to answer if you are lost.

From Richmond Road and Man O War. Go toward Hamburg/I-75 on Man O War. Our office is on your left just after Palumbo Drive and Lexington Furniture. Turn Left on Darby Creek Road and left into the complex. My building is the second on the right.

From I-75 take Man O War toward Lexington. Darby Creek Road is about 1 mile on your right. Turn right on Darby Creek then make and immediate left into the office complex. My building is the second on the right.

We are in suite 11 after you enter on your right. Our suite is marked only by 11.



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Directions are available on our website at <http://www.ezcounseling.com/directionsrichmond.html>

Please be advised we will be in session and likely not be able to answer a phone call if you are lost. You may try our office number above or our Lexington office for help.

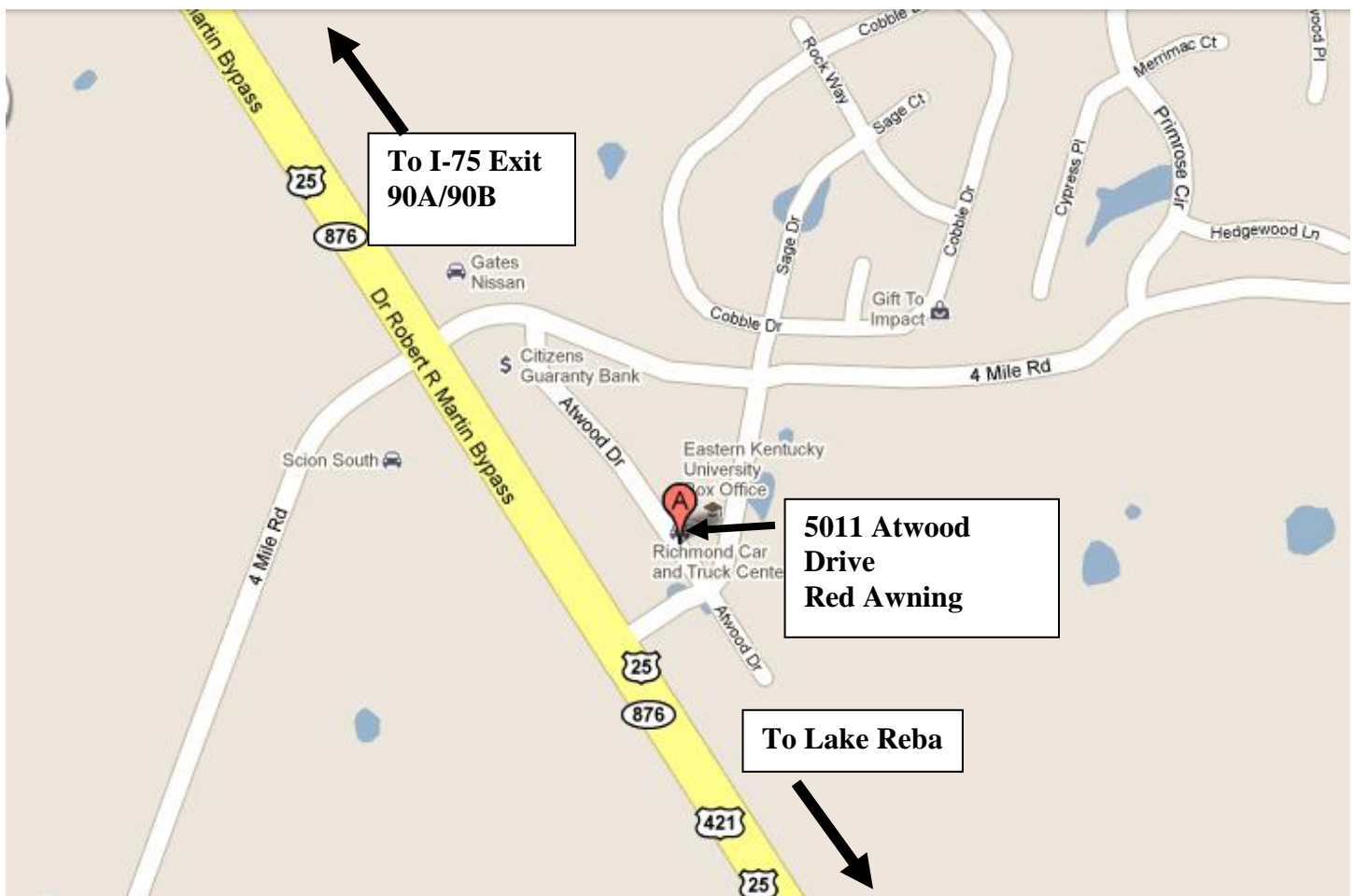
Directions to our Richmond Office: 5011 Atwood Drive, Richmond, KY

From I-75 Take exit 90B

Go toward Lake Reba on the bypass.

Take a Left on 4 Mile Road at the Gates Nissan Dealership and The BP station.

Take a quick right on Atwood Drive. Our office is 5011, the first suite on the left end of the building with the blue awning right next to Starr Mortgage.



Please have a seat in our waiting area when you enter the office. We will likely be with a client until our meeting. If for some reason we are not yet there, please be aware we do sometimes show up exactly on time. Thank you for choosing our office.

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Directions to our Frankfort office can be found at: <http://www.ezcounseling.com/directionsfrankfort.html>

Directions to our Frankfort office: 80 C. Michael Davenport Blvd., Suite A, Frankfort, KY

Please be advised we will be in session and likely not be able to answer a phone call if you are lost. You may try our office number above or our Lexington office for help.

From US 127, turn on to Kings Daughter Drive.

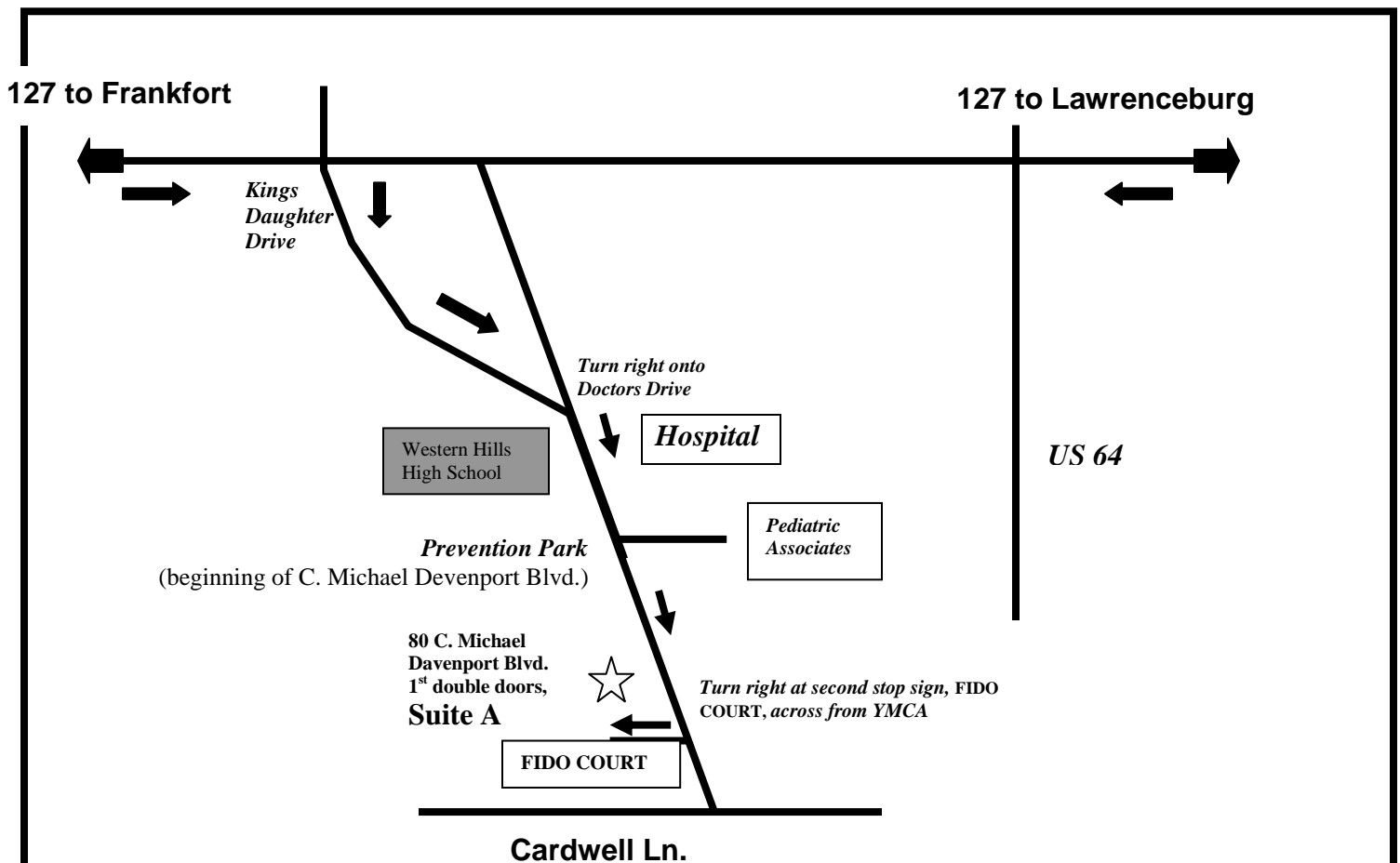
At the traffic light turn right onto Doctors Drive.

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, Suite A.



Please have a seat in our waiting area when you enter the office. We will likely be with a client until our meeting. If for some reason we are not yet there, please be aware we do sometimes show up exactly on time. Thank you for choosing our office.