Counseling Services Application

Personal Information			**Assigned Counselor:**	
First Name	Middle Initial	Last Name		Today's Date
Mailing/Street Address		City	State	Zip
Preferred Phone: ☐Home ☐ Cell ☐ Work -May we leave a message? ☐Yes ☐ No				Email Address:
Other Phone: ☐Home ☐ Cell ☐ Work -May we leave a message? ☐Yes ☐ No				
Birth Date:	Sex: ☐ Male ☐ Female	Employer Name:		
List present or previous health problems:		List any medications you are currently taking:		
Bishop's Name		Home Phone:	Work Phone:	Cell Phone:
Ward		Stake		

☐ Spouse ☐ Parent Information if under 18			
First Name	Middle Initial	Last Name	Marriage Date:
Mailing/Street Address	City	State	Zip
Preferred Phone: ☐Home ☐ Cell ☐ Work -May we leave a message? ☐Yes ☐ No			Email Address:
Birth Date:	Sex: ☐ Male ☐ Female	Employer Name:	
List present or previous health problems:		List any medications you are currently taking:	

Children's Information: List all children

Name	Birth Date	Lives with you?	Name	Birth Date	Lives with you?

Insurance Information		**Payment Arrangements: ☐ Client ☐ Ward ☐ Insurance**	
Insurance Company Name	Policyholder	Policyholder's birth date	Applicant's relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Company Address			Phone
Policy Number		Co-pay amount	Group Number

Other Information (PLEASE COMPLETE THIS SECTION)	
What do you hope to change or accomplish by seeking help at this time? (Use the back of the form if more room is needed.)	
List any agencies or other professionals who have provided you counseling services in the past. (Use the back of the form if more room is needed.)	
Signature	Signature (spouse)

Therapy Services – Authorization for Release of Confidential Information
Karla K. Chamberlain, MA, LMFT

CLIENT NAME: _____ CLIENT NAME: _____

I authorize LifeFamilyMatters, LLC, and Karla K. Chamberlain, MA, LMFT and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I have received and reviewed Karla Chamberlain's *Notice of Privacy Practices*.

I understand that only Karla K. Chamberlain MA, LMFT or employees of Karla K. Chamberlain MA, LMFT can ask me to sign this authorization.

I understand that by signing the *General Authorization* I am authorizing Karla K. Chamberlain MA, LMFT to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Karla K. Chamberlain MA, LMFT. My health information includes, without limitation, any records, reports, test results, opinions, assessments, and any other information relating to medical, emotional, educational, or psychological condition. Disclosures may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Karla K. Chamberlain MA, LMFT where I am receiving therapy. I understand that my revocation of this General Authorization will not affect a disclosure that Karla K. Chamberlain MA, LMFT has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the confidentiality rules of Karla K. Chamberlain MA, LMFT.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

This authorization is valid until _____, or until three months after my file is closed with Karla K. Chamberlain MA, LMFT.

_____	_____	_____
Bisho	Ward	Client's Initials
_____	_____	_____
Insurance	Address ID#	Client's Initials
_____	_____	_____
Name	Address	Client's Initials
_____	_____	_____
Name	Address	Client's Initials
_____	_____	_____ ___
Name	Address	Client's Initials

SIGNATURES:

_____	_____	_____	_____
Client's Signature	Date	Client's Signature	Date
_____		_____	
Name of Parent or Guardian		Name of Parent or Guardian	
_____	_____	_____	_____
Witness	Date	Witness	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Why We are Providing You with This Notice
We are required by a federal law known as the Health Insurance Portability and Accountability Act (HIPAA) to give you this Notice. This Notice will tell you about the ways in which we may use and disclose health information about you and will describe your rights and our obligations regarding the use and disclosure of that information.

Your Health Information
This Notice applies to the information and records we have about your health, health status, and the healthcare services you receive from Karla Chamberlain, LMFT. This information and records relates primarily to counseling services you have received from us.

How We May Use and Disclose Health Information About You

For Treatment
We may use or disclose health information about you to facilitate counseling and other health treatment. For example, your counselor might disclose information about you to another counselor so that the counselor can determine the most appropriate care for you.

For Payment
We may use and disclose health information about you so that we can be paid by you, an insurance company, or another party, including current or future bishops if they are paying any portion of the fee for the services we provide for you. For example, we may need to give your insurance company information about our services to you so the company will pay us for these services.

For Agency Operations
We may use and disclose health information about you in order to run our office and make sure that you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of our staff or to contact you to remind you of your appointments.

Please notify us in writing if you do not want us to contact you to remind you of your appointments.

Special Situations
We may use or disclose your health information without your permission for several reasons. These reasons include:

- Disclosing your health information when we believe that disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- Disclosing your health information as required by federal, state, or local law
- Disclosing your health information as required by law to prevent injury or suspected abuse or neglect.
- Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process.

Other Uses and Disclosures of Health Information
Except where otherwise required or authorized by law, we will not use or disclose your health information for any purpose without you written authorization. If you authorize us to use or disclose health information about you, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization, but we cannot take back any uses or disclosures we have already made with your permission.

Your Rights Regarding Your Health Information
You have the following rights with regard to your health information:

- You may inspect and copy you health information, with certain exceptions.
- If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information.
- You may obtain an accounting of our disclosures of your health information. This is a list of all of our disclosures of you health information for purposes other than treatment, payment and health care operations.
- You have the right to request that we restrict or limit our use or disclosure of your health information to only treatment, payment or health care operations. We are not required to comply with your request.
- You may request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- You have the right to receive a paper copy of this notice.

If you want to exercise any of these rights, please contact the supervisor, in writing, at the office where you are receiving counseling.

Changes to This Notice
We have the right to change this notice. If we do so, the new notice will apply to the health information we may already have about you and to the health information that we receive in the future. We are required to abide by the most current notice that is in effect. We will post a summary of the most current notice in our office. You are entitled to receive a copy of the most current notice.

Complaints
If you believe your privacy rights have been violated, you may file a complaint without our office or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Karla Chamberlain, LMFT, please contact her directly at 423-508-9798. You will not be penalized for filing a complaint.

This notice is effective as of January 1, 2021

Signature: _____ Date: _____

Print: _____

Signature: _____ Date: _____

Print: _____

LifeFamilyMatters

Karla K. Chamberlain MA, LMFT

DESCRIPTION OF SERVICES

Welcome to LifeFamilyMatters. I hope your visit and our work together will be worthwhile. The following information is important for your consideration. Your goals are more likely to be met when you understand the nature and limitations of therapy.

Goals and Outcomes:

Generally, therapy is most useful in helping individuals help themselves or improve relationships by changing feelings, thoughts, and/or behaviors. YOU determine the nature and amount of change you wish to make. Choosing a goal and working toward that very goal will enable a focus that allows for deeper and longer-lasting change.

Benefits and Risks:

Most people experience improvement or resolution to the concerns that brought them to therapy, but there are no guarantees and there are some risks. For example, therapy could open up new levels of awareness that may cause discomfort. Also, positive change is not always easy, sometimes significant sacrifices must be made to allow room for the needed growth.

Length of Therapy:

Together, we will come up with a plan for your treatment and how long the process may take. Generally, I lean toward solution-focused therapy, which means approximately 12 sessions. This is not exact as it depends on diagnosis and goals set. If it seems you need more time and are invested in the process, time can be extended.

Confidentiality:

I understand that the information you share in therapy can be very personal and that you may not want me to share this information to others without your authorization. By signing this *Description of Services,* you acknowledge the receipt of the Privacy *Practices.* This document describes your rights and our obligations regarding the use and disclosure of that information. All clients will be asked to sign an *Authorization for Release of Confidential Information.* Office

personnel will not release confidential information without this written authorization, unless such release is otherwise authorized or required by law. For example, the law requires us to report confidential information if there is reason to believe that a child, an elderly person, or a severely disabled individual has been abused or neglected, or you may be in danger of harming yourself or others.

Payment for Services:

The fee for services is $110.0 per clinical hour. Additional time will be charged in one-half hour increments. Clients are responsible for payment of services AT THE TIME OF SERVICE. Payments are made to the office at the beginning of each session. Cash and Check are payment options. When requested, I will be your ecclesiastical leader if he/she has authorized payment. If you indicate that insurance,or an ecclesiastical leader will be paying for any portion of your bill, you must sign an *Authorization for Release of Confidential Information* to allow contact with the paying party. If this paying party changes during the course of therapy, you must discuss this with the new party, notify me, and sign a new *Authorization for Release of Confidential Information* form. If your bill is partial client pay, then YOUR PORTION of the bill is due at the AT THE TIME OF SERVICE and the ecclesiastical leader or insurance will be billed separately.

Cancellation of Appointment:

On occasion, a situation may arise which prevents you from keeping a scheduled therapy appointment. As a courtesy to the office, please notify me by 7am by text, email, or phone message that you cannot keep your appointment. You may text or email at any hour in the night for cancellations - I will pick up the message in the morning. Except in emergency situations, you will personally be charged for one-half the current hourly fee for late cancellations or no showing for an appointment. That fee will be due before the next session begins.

Grievance:

If you have concerns about any aspect of the services you are receiving, please talk with me. I am open and honest and care about the quality of your care. We should collaborate to make this the best experience for you. If you are unhappy with services but feel you need to continue therapy, I will provide a community referral for you.

Other Areas of Discussion:

I encourage and welcome discussion about your therapy and your therapist. Following are questions you might consider asking.

1. What is the background of your therapist?
2. What does your therapist feel most qualified to treat?
3. Following the assessment interview, you may ask how your therapist intends to help you, or what methods may be used and how long it might take.
4. You may ask about other interventions such as marriage therapy, family therapy, group therapy, etc.
5. You may ask how a referral is handled if one is needed.

***** Please arrange for small children to remain at home unless discussed with your therapist, or specifically asked to bring them as part of family therapy. CHILDREN MAY NOT BE LEFT UNATTENDED IN THE WAITING AREA.**

I have read the above information and understand I am encouraged to ask questions and give input regarding the therapeutic process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

Based on my decision, it is my understanding that payment arrangements are as follows:

Client: _____ Ecclesiastical Leader: _____

Ecclesiastical Leader Approval: _____ Date: _____

Insurance Copay or Agreement: _____

Signature: _____ Date: _____

Print Name: _____

Signature: _____Date: _____

Print Name: _____