

I am very pleased that you have chosen me as your counselor and are allowing me to be a tool in reaching your personal goals. I appreciate your confidence in contacting me for assistance. Below is a brief explanation of the things that will be helpful in preparing for your first visit.

Online Account:

- ✓ Upon receiving this packet, you should have an account on our scheduling software. If not, see the scheduling appointment section below to register. Please fill out as much information as possible on your account. Should you forget your username or password please email me. The online system requires each individual person seen to have an account; therefore, if I am to see multiple children in the family, each must have their own account. If you are coming as a couple, please pick one person to have the account under.

Paperwork (see attached):

- ✓ Please review, sign, and bring all the attached paperwork to our first visit together – Declaration of Practice and Procedures, Notice of Privacy Practices Consent Form, and Policy for Cancellations/No Shows. If you do not print out the forms, you'll need to allow 20 minutes to fill them in when you arrive so you won't lose any of your therapy time. I ask as a new client that you fill out the new client forms in their entirety.

Scheduling Appointments:

- ✓ Upon receiving this packet, you should have an account on our scheduling software. If not, utilize the directions below and register as a new client. Please access this portal to schedule or cancel any future appointments. Here is the best way to get back to the portal should you need it - go to www.gracechristiancounseling.org, scroll down and click on button that says "existing clients online scheduling." This will lead you to the scheduling portal. This portal can be utilized at any time to schedule or cancel appointments. You may also go directly to www.therapyappointment.com and search for me by last name.

Confirmation of Appointments:

- ✓ When creating your online account in the scheduling portal you can elect to have your appointments confirmed through text, email, or automated phone call. However, whether an appointment is confirmed or not, you are still responsible for remembering your appointments and will be charged if you miss per my cancellation policy.

Therapy Fees:

- ✓ Please review the attached Declaration of Practices and Procedures for my fee schedule. I am a provider for Blue Cross Blue Shield (HMO and PPO). If utilizing insurance, **it is your responsibility** to find out the following information prior to using health insurance: determine that I am on the "provider" list for your insurance, the number of sessions authorized, your co-payment, and the amount remaining on your deductible. If your deductible is not met, I will bill your insurance accordingly however, **you are responsible for payment in FULL per the contracted rate until your deductible is met.** Fees/co-payments are due at the time of service. Payment can be made by cash, check, or credit card (Master Card or Visa Only). If paying with cash you must have exact fee or you will be issued a credit toward your next visit. If you have another insurance provider, I can provide you with the information you need for you to file out of network benefits for personal reimbursement.

Credit Card on File:

- ✓ To secure your appointment, we MUST have your credit card number on file PRIOR to your arrival for the first session. It is safely secured through encryption. You can call the office at 225-308-9314 with a credit card number, and we will charge a penny to your account, or you can login to your account on TherapyAppointment.com and enter your information directly:

1. Login and click where it says "View or pay online statement"
2. Go to "Do you want to make a payment?"
3. Go to: "Please charge a _____ to a new charge card". On the blank fill in \$.01
4. Fill in the name on the card, street address, and zip code
5. Click "Submit payment to charge card"
6. Verify by clicking "Yes"
7. Put in your credit card number, expiration date and security CVV code from the back
8. Then click on "Process"

DONE! Your credit card information is safely stored and encrypted in our system

Cancellations:

- ✓ If you ever need to cancel - I need at least 24 hours' notice, preferably 48 hours, or I have to charge your credit card per our cancellation and no-show policy. See Policy for Cancellations/No Shows for more information. I really appreciate your understanding so I can schedule other clients in need of counseling. You can call and leave a voicemail at any time 7 days a week or emailing me is acceptable.

Wait List:

- ✓ If you now, or ever, want an earlier appointment and no appointments are currently available – email me or call and ask to be put on my waiting list. I will email, text, or call you if something opens up sooner. I sometimes email out notice of last minute cancellations as well.

Getting Here:

- ✓ My office is in the Grace Life Fellowship church campus located at 10210 Barringer Foreman Road. This is near the I-10 Highland Road exit. The church is set back from the street down a long driveway. Please enter through the front right door of the church office and be seated in the waiting area. If the door is locked, please use the buzzer. You may want to allow extra time to find for your first session, especially given Baton Rouge's traffic.

If you have any questions, or want to give me some background information before the first session, please feel free to email me.

I am looking forward to meeting with you and beginning your counseling journey!

Kyndal

Declaration of Practices and Procedures

I am very pleased that you have chosen me as your counselor and are allowing me to be a tool in reaching your personal goals. I appreciate your confidence in contacting me for assistance. This statement is designed to inform you of my background and to ensure that you understand our professional relationship. **After reading, please sign and date the last page.**

1. Counseling Relationship:

In an effort to promote a positive therapeutic environment, it is my desire to provide a safe, warm, and open atmosphere in which you feel free to examine your thoughts, emotions, and patterns of behavior which are of concern to you. It is my desire to establish a counseling relationship based on mutual respect, trust, and honesty.

My approach to counseling is multi-theoretical and utilizes a diverse array of techniques and strategies that will allow me to best meet your needs while addressing areas of concern, patterns of behavior, thought patterns, and mood. Through this approach it is my hope that we will work together to accomplish your goals in counseling.

After gathering information, addressing any concerns or hesitations you may have, and becoming acquainted, goals are established through collaboration of the counselor and client. The ultimate goal of therapy is the successful resolution of the problems that are deemed most important by the client. Oftentimes I may ask you to complete assignments outside of session. These are used for you to get the most out of your counseling experience.

It is my goal to assist you in the problem-solving process; however, my code of ethics does not allow me to advise you to make a specific decision. Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation.

As a Christian counselor, I believe God is able and eager to help facilitate emotional and spiritual growth. I seek God's guidance through the Holy Spirit and may use Scripture and prayer when appropriate and only at the comfort of the client. It is not at all necessary that you share my view. I will respect your spiritual beliefs and am willing to explore your personal belief system as you give direction.

2. Qualifications:

I received my Master of Social Work degree from Louisiana State University in 2009. I earned a Bachelor's Degree in Family, Child, and Consumer Sciences from Louisiana State University in 2006. During my graduate studies, I completed internships with Youth Oasis, Capital Area Human Services District, and Louisiana State University Mental Health Center. I am a Licensed Clinical Social Worker (LCSW) granted by the Louisiana State Board of Social Work Examiners, 18550 Highland Road, Suite B, Baton Rouge, LA 70809, (225) 756-3470. My license number is 10546.

3. Areas of Expertise:

I have a general counseling practice that includes individual, marriage, family, and couples counseling. Additional areas of interest and experience include the treatment of depression, anxiety, grief, anger management, self-esteem, relationship difficulties, family of origin issues, parent/child relationship concerns, family and couples counseling, and trauma. I also thoroughly enjoy working with young adults and those in life transitions.

4. Session Fees:

I accept private pay and Blue Cross Blue Shield (HMO and PPO plans). It is your responsibility to find out the following information prior to using health insurance: determine that I am on the "provider" list for your insurance, the number sessions authorized, your co-payment, and the amount remaining on your deductible. If your deductible is not met, I will bill your insurance accordingly; however, you are responsible for payment in FULL until your deductible is met. If you have

another insurance provider, I can provide you with the information you need for you to file out of network benefits for personal reimbursement.

Fees/co-payments are due at the time of service. Payment can be made by cash, check, or credit card (Master Card or Visa Only). Payment is due at the time of service. Clients using insurance are required to make the co-pay at the time of service. When paying with cash you must have exact fee or you will be issued a credit toward your next visit. Please write checks out to Kyndal Jacoby. The final obligation for payment lies with you, the client, not the insurance or managed care companies. Fees are subject to change. There will be a \$50.00 NSF charge on all returned checks.

➤ **Any balance past due after 30 days will automatically be charged to your credit/debit card on file.**

Service	Charge
Initial Evaluation (1 st session) – <u>60 mins</u>	\$140
Individual, Family, Couples Session – <u>60 mins</u>	\$115
Individual, Family, Couples Session – <u>50 mins</u>	\$100
NSF Charge (Returned Checks)	\$50

CANCELLATIONS

THE TIME YOU SCHEDULE FOR APPOINTMENTS IS RESERVED FOR YOU. In the event you are unable to keep an appointment, a **24-hour advance notice** will allow for the scheduling of another person who may benefit from the time. **IF NOT CANCELED with 24-hour notice, YOU ARE RESPONSIBLE FOR PAYMENT OF THE UNUSED TIME, which is the full session fee of \$100.00/115.00.** You can call if there is a need to cancel at any time- 24/7, you can leave a voice message in our voice mail at **(225) 308-9314** and the time will be registered. You may also email me (kyndal@gracechristiancounseling.org) to cancel an appointment 24 hours in advance. **Automated reminders are sent, although responsibility for remembering appointments rests with the client.**

5. Explanation of the types of services and client population:

Individual counseling (ages 13 & up), Family counseling, and Couples counseling are available.

6. Code of Ethics:

I am required by state law to adhere to the Louisiana Code of Conduct for Louisiana Licensed Clinical Social Workers. Copies of this code is available upon request.

7. Privileged Communication/Confidentiality:

I am required to abide by the professional practice standards and Louisiana law. I do not disclose client confidences and information to any third party except for materials shared during supervision without clients written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other

parties from a clear and imminent threat of serious physical harm. Certain types of litigation may lead to the court-ordered release of information without your consent.

When working with couples, families, or groups I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. When working with a family or couple, information shared by individuals in sessions, when other family members are not present, must be held in confidence (except for the mandated exceptions already noted) unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy.

8. Litigation Limitation:

Given that certain types of litigation (such as child custody suits) may lead to the court ordered release of information without your consent, it is expressly agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you or any attorney, or anyone else acting on your behalf, will call Kyndal Jacoby to testify in a deposition or in court or any other proceeding, nor will a disclosure of any information contained in the chart, including but not limited to the psychotherapy notes, as defined and protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) be requested.

9. Physical Health:

Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical within the last year, it is recommended that you do so. Also, you agree to list any medications that you are taking on the intake form and who your primary care physician is.

10. Telephone Consultations:

Telephone consultations are rarely recommended, but are available as scheduled on a fee basis.

11. Potential Counseling Risks:

As a result of mental health or individual/couples/family counseling, the client may realize that he/she has additional issues; which may not have surfaced prior to the onset of the counseling relationship. Specifically, these issues may present possible risks in couple or family counseling. If one partner changes, additional strain may be placed on the relationship if the others involved refuse to change. Marital or family conflicts may initially intensify as feelings are expressed. If any of the aforementioned concerns occur, the client(s) should feel free to share these new concerns with me.

12. Emergency Situations:

In case of emergency, call 911, The Crisis Intervention Center (The Phone) at (225) 924-3900, a psychiatric hospital, and/or go to the nearest emergency room, if warranted.

13. Client Responsibilities:

You, the client, are a full partner in counseling. Your honesty and effort are essential to your success. The client is expected to follow billing, scheduling and office procedures. If you have suggestions or concerns about your counseling, I invite you to share these with me so that we can make the necessary adjustments. If you or I come to believe that you would be better served by another mental health provider, I am happy to help you with the referral process. If you are currently receiving services from another mental health professional, I need you to inform me of this in order to coordinate your treatment. I may ask you to grant me permission to obtain information from or share information with that professional.

I have read, or have had read to me, and understand the above information. I hereby sign in agreement and authorize this provider to release information to my primary care physician as needed. I also hereby sign in agreement and authorize this provider to release any information necessary to obtain assignment/payment of health care benefits from third party insurers, such as health insurance companies, HMO or PPO plans, or EAP programs, for the above services.

Client Signature _____ Date _____

Kyndal C. Jacoby, MSW, LCSW _____ Date _____

If client is a minor, parental authorization is needed: I, _____, give

permission for Kyndal C. Jacoby, MSW, LCSW to conduct therapy with my

_____, _____
(Relationship) (Name of Minor)

Policy for Cancellations & “No Shows”

Kyndal Jacoby, MSW, LCSW
Grace Christian Counseling
(225) 308-9314 (24-hour voice mail)

I, _____, agree to have my/our
Print Name(s)

MasterCard or Visa charged the **FEE OF \$50 for first appointment and the FULL FEE of \$100 (50min) or \$115 (60min) for all successive appointments:**

- 1) for any session not cancelled with ***at least*** 24-hour notice, and/or
- 2) for any appointment, I/we neglect to appear (“no show”)
- 3) for any balance owed 30 days past due.

Signature

Date



GCC’s policy is that payment is due at the time of the session.

Confirmation of appointments is provided as a courtesy. **Keeping the appointment is the responsibility of the client.**

All new or returning clients will need to have a credit card number on file before scheduling their first or a new appointment.

Credit cards numbers will be securely stored in our scheduling system.

PLEASE FILL IN THE INFORMATION BELOW

CARD TYPE  <input type="checkbox"/> MASTERCARD  <input type="checkbox"/> VISA		
CARD NUMBER:	SECURITY CODE:	ZIP CODE:
CARDHOLDER NAME:	EXP DATE:	
SIGNATURE:	AMOUNT: Maximum of \$100/\$115 for missed appointments or ANY balance due past 30 days	

Grace Christian Counseling

Phone (225) 308-9314

10210 Barringer Foreman Road
Baton Rouge, LA 70809

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003 a federal regulation, commonly known as the “HIPAA Privacy Rule”, requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy “*Notice of Privacy Practices*” available in our waiting room and it is also on our web site: www.gracechristiancounseling.org. A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Grace Christian Counseling may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the “*Notice of Privacy Practices*” may change over time, and that I have a right to obtain any revised Privacy Notices, if requested.

I also understand that I have the right to request GCC to restrict how my health information is used or disclosed. GCC does not have to agree to my request for the restriction, but if GCC does agree, GCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that GCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Signature

Date

Signature

Date

Signature

Date

Grace Christian Counseling
Intake Form for Minors

TO HELP WITH YOUR CHILD'S FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.

PLEASE NOTE: ALL INFORMATION IS CONFIDENTIAL

Date _____ Child's Age _____ Child's Date of Birth: _____

Name of Child _____

Parent's Name _____

Address _____ ZipCode _____

Contact Number: _____

Person responsible for the bill: _____ same as above or:

Name _____

Mailing Address _____

Father's Occupation _____

Cell number _____

Mother's Occupation _____

Cell number _____

Name of School _____

Grade _____ Teacher _____

Any Church Membership _____

How often does the family participate in some type of religious activity? _____

Briefly describe your family's spiritual life: _____

Who referred you to me? _____

Pediatrician: _____

Person to contact in case of emergency _____

Name _____ Phone number _____

List all members of the family (including anyone living in the house) by name and their age:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Has your child or any member of your family ever had counseling before? _____ yes _____ no

If yes, describe and list counselor: _____

What concerns you most about your child? _____

When did the problem start or when did you first notice it? _____

Has your child's eating or sleeping habits changed? _____

What would you like your child to get out of counseling? _____

What have you tried so far? _____

Describe your child's personality - focus on strengths. _____

Have there been any physical and/or psychological stressors in your child's life - moves, separations, deaths, abuse, etc.?

At what age did these occur?

How does your child react to stress?

Has anyone in the extended family had a similar personality and/or problems?

What has been your biggest struggle with this child?

Do both parents work outside the home?

How is alcohol handled in the home?

Does either parent use alcohol or drugs? yes no

If yes, describe frequency and type

Does your child have any speech difficulties? yes no

If yes, explain

Does your child have any physical handicaps? _____yes _____no

If yes, explain _____

Does your child have any hearing or vision difficulties? _____yes _____no

If yes, explain _____

Does your child have any special fear? _____yes _____no

If yes, explain _____

Does your child like to read?

_____none _____little _____moderately _____much

When your child is doing homework, do you help him? _____yes _____no

If yes, explain what you help him with and how long it takes you to help him.

Any difficulties with school? _____

If separated, divorced, or unmarried:

Does your child see the other parent? _____yes _____no

Briefly describe child relationship with other parent? _____

Briefly describe child relationship with step-parent? (if applicable) _____

Is your child taking any prescription drugs at this time? _____yes _____no

If yes, what type, what purpose, and who prescribed it? _____
