Cahaba Counseling
128 North Chalkville Road
Trussville, AL 35173

KD Counseling
300 3rd Avenue East
Oneonta, AL 35121

Client Information Form - Katherine Dalstra,LPC, ALC

662-408-6965 katiedalstralpc@gmail.com

Today's Date _____ Cell Phone _____
Work Phone _____

Client's Name/s_____
Address _____City _____State _____Zip _____
E-mail_____
Age/s _____ Date/s of Birth _____
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Employer-Self_____ Occupation_____
Employer-Spouse_____ Occupation_____

How would you like to receive your appointment reminders?
❑ Text message ❑ Email ❑ Both ❑ None
Where would you like me to leave you messages? ❑ Home ❑ Work ❑ Cell ❑ E-mail ❑ None

Why are you seeking counseling?
_____
_____
_____

Are you currently in counseling elsewhere? ❑ Yes ❑ No ***If yes, do not complete this form***

How were you referred to our office? ❑ FBCT website ❑ Psychology Today
❑ Word of Mouth ❑ Provider Referral _____ ❑ Other _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?
Name_____ Relationship to Client_____
Address _____City, ST _____ Zip _____
Date of Birth _____ E-mail _____
Cell Phone _____ Alternate Phone _____
I understand that a card will be kept on file when I schedule an appointment and that card will be charged after each session. _____ (Initial) Last 4 digits of the card on file: __ __ __ __

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ABOUT YOUR HEALTH

Primary care physician/s: _____

Any concerns shared by the doctor? _____

Describe any allergies you have: _____

Do you have any chronic medical concerns? ❑ Yes ❑ No
If so, please list:

_____

_____

Do you have a mental health diagnosis? ❑ Yes ❑ No
If so, please list:

_____

_____

Are you under the care of a psychiatrist? _____ If so, whom? _____

Have you been prescribed any psychotropic drugs by your psychiatrist? ❑ Yes ❑ No
List all medications or drugs (legal or illegal) you have taken in the last year:

_____

List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have had.

_____

_____

_____

Emergency Contact

Name: _____ Relationship: _____

Phone number: _____

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Professional Disclosure Statement and Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that Katherine Dalstra, ALC is an Associate Licensed Counselor in the state of Alabama and is being supervised by Donna Marsh, LPC-S.

_____ I understand that Katherine Dalstra, ALC does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 911 or go to an emergency room for assistance.

_____ I understand that during the time that we work together, we will meet together weekly or bi-weekly. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

_____ I also understand our contact will be limited to counseling sessions except, only in case of emergency, you may call Katherine Dalstra, ALC at (662)408-6965

_____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that specific results are not guaranteed although benefits are expected from counseling.

_____ I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes can be temporarily distressing.

_____ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Katherine Dalstra, ALC's services as a therapist, I have a right to let her know. If I do not feel Katherine Dalstra, ALC may resolve my complaint, I may file a formal complaint through contact with the Alabama Board of Examiners of Licensed Professional Counselors at 1-800-822-3307.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that Katherine Dalstra, ALC will not initiate the greetings.

_____ Should I believe that a referral is needed, Katherine Dalstra, ALC will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that conducting expert witness and testimonial services is not an area of interest of Katherine Dalstra, ALC and should I subpoena Katherine Dalstra, ALC as a factual case witness or involve her in any court-related processes, Katherine Dalstra, ALC charges a retainer fee of $1000.00, with an additional $130.00 every hour she is involved in legal depositions, case preparation, travel, and witness time.

_____ I understand that if I do issue Katherine Dalstra, ALC a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Katherine Dalstra, ALC. Client records are disposed of seven (7) years after the client has stopped receiving services

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Charges and Cancellations:

_____ I understand that the rate for individual counseling sessions is $110.00 for a 1-hour session, and the rate for couples and family counseling is $130.00 for a 75 minute session. The initial intake and assessment is $130.00 for individual and couples/family therapy.
_____ I understand that all fees for counseling are due at each session.
_____ I understand that if I do not cancel my appointment at least 24 hours ahead, that spot will not be filled, so I will be charged a $70.00 late cancellation fee.
_____ I understand that if I do not show up for an appointment, it will result in my being charged the full fee ($110 or $130) for that missed session.
_____ I understand that if I need to reschedule or cancel a session, I need to contact my therapist directly at 662-408-6965.

Limits to Confidentiality:

_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Katherine Dalstra, ALC is ordered by a court to disclose information.
- You Katherine Dalstra, ALC in writing to release your records.
- Katherine Dalstra, ALC is otherwise required by law to disclose information.

MENTAL STATUS INFORMATION

Have you or your spouse/significant other ever attempted suicide or harmed yourself in any way? ❑ Yes ❑ No

Are you or your spouse/significant other currently thinking about suicide or harming yourself in any way? ❑ Yes ❑ No

Have you or your spouse/significant other had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ❑ Yes ❑ No

Are you or your spouse/significant other having any thoughts about harming anyone else in any way? ❑ Yes ❑ No

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STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

_____

Client Signature Date

AGREEMENT FOR THERAPY

I,_____

❏ Agree to receive therapeutic services provided by Katherine Dalstra, MA, ALC.

❏ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.

❏ Furthermore, I understand that I am expected to be an active participant in this process.

❏ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

❏ My signature below means that I understand and agree with all the points above.

_____

Client Signature Date

HEALTH PROVIDER'S STATEMENT

I have inquired to ensure that the patient understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

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HIPPA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other his use required by law.

Treatment:
We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations:
We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with This practice, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the

following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office.

_____

Client Signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Katherine Dalstra, MA, ALC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____

Client Signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke This consent in writing, except to the extent that This office has previously taken action in reliance on This consent. Your treatment by This office is conditional on your signing This consent

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Telehealth Counseling Session Consent Form

I, _____am choosing to receive counseling sessions

with ___Katherine Dalstra, LPC_____ at *Restoration Counseling Center(RCC)/K.D.Counseling* via the internet and the Doxy.com/Zoom.com/VSee.com program for outpatient mental health. By choosing this option, I understand that:

• Any online communication tool utilized by RCC allowing face-to-face video, voice, or text-based chat/dialogue is encrypted using HIPAA compliant standards –sufficient for non-government providers— to protect sensitive information.

• Telehealth software should be downloaded on a secure computer. The client must set up a personal account on the platform chosen and invite the clinician to access the account as a contact. The client can choose a username that does not identify them by their proper name. To ensure privacy, download the program on your personal computer or smart device and use a password protected internet connection when online.

• NO internet-based communication is not 100% guaranteed to be secure/confidential. RCC has made every reasonable effort to implement technical security measures that reduce risks of a confidentiality breach. Therefore, RCC should not be held responsible if any outside party gains access to your telehealth account information or transaction by bypassing online security measures.

• I agree that I will refrain from using telehealth platforms in an emergency situation that needs immediate attention, whereby I am considering harming myself or someone else. If a life-threatening crisis should occur, I agree to contact 911 or the 24-hour suicide hotline at 1-800-SUICIDE, or go to the nearest Emergency Room.

• In addition, I understand that technical problems may occur. If a call is disrupted, the therapist will call back unless technical difficulties persist. In such cases, the session can be rescheduled via email or by phone as indicated on the client's intake paperwork.

• Telehealth counseling sessions are not to take the place of regular in-office therapy sessions, but are utilized when in office sessions are not possible for health reasons, unforeseen circumstances, and ONLY for a predetermined length of time which the therapist and client deem necessary for continuity of care.

•The client is responsible for ensuring confidentiality by closing other programs on their computer while in an e-session, planning ahead to minimize distractions, and not answering the phone while on their telehealth program call with their clinician.

• I also agree to be on time for my telehealth sessions and to be online at least five (5) minutes prior to the scheduled telehealth session appointment (preferably in a quiet room alone with the door closed).

• The clinician will call the client at the scheduled appointment time.

Client Signature _____ Date: _____