Today's Date:_____

Brian P. Heydon, Ed.S, LPC
8080 Ward Parkway, Suite 330
Kansas City, MO 64114
816-523-1600

Client Name:_____Birth Date:_____Age:_____

Client Name:_____Birth Date:_____Age:_____

Client Name:_____Birth Date:_____Age:_____

Client Name:_____Birth Date:_____Age:_____

Address:_____City_____State_____Zip_____

Phone number (s):_____ May we leave messages? y/n

Email Address:_____ May we send email to this address? y/n

Employer Name:_____ Address: _____

Occupation:_____

Doctor's Name :_____ Phone #:_____

Referred by:_____

Emergency Contact:_____ Relationship to client:_____

Phone number:_____

Your therapist will submit an insurance claim on your behalf, or provide you with a completed receipt or claim form at your request. Please provide a copy of your insurance card if you wish to submit a claim.

I authorize my therapist to contact my emergency contact if warranted:

Client signature:_____ Date: _____

POLICIES AND PROCEDURES FOR COUNSELING

1. I understand that my therapist will work with me to develop a treatment plan that will deal with my reasons for counseling as quickly and effectively as possible.

2. I understand that each clinical hour is 50 minutes long. If I am late, that time is lost from my session. If I am more that 20 minutes late, I may not be seen, but I am still responsible for payment for the session. If my therapist is running late, I will still be seen for 50 minutes or the time will be made up to me at a later date.

3. Fees for a 50-minute session are $160.00. Fees for a 75-minute session are $240.00. Fees for administrative services (such as writing reports or letters, preparing for legal presentation, etc.) are $160.00 per hour initially and $40 for every15 minutes thereafter. Fees for phone conversations that extend beyond appointment scheduling, confirmation, and cancellations will be billed to me at $40 per 15-minute increment.

4. I understand that I am responsible for all charges incurred by me as a result of seeking treatment from my therapist.

5. Fees for services are due at the beginning of every session. If I plan to submit my fees to an insurance company, I will ask my therapist to file an insurance claim as a courtesy. I understand that I am responsible for collecting all reimbursements from my insurance company.

6. I agree to provide a debit or credit card to be kept on file in order to secure ongoing appointments. I authorize my therapist to collect payment of all co-pays, deductibles, balances due, late cancel fees, and no show fees to this debit or credit card. I understand that I am responsible for all of these fees and I authorize my therapist to charge these fees to my debit card or credit card.

Card number_____ Expiration date (month/year)_____ CVV Code_____

7. I understand that the time I have reserved with my therapist cannot be offered to anyone else. Charges for a missed appointment, not canceled 48 hours in advance, will be billed to and paid by me at the regular hourly rate. A phone call or text to cell number 816-523-1600 is the only form of communication that will be considered valid. Email will not be considered.

Signature_____

8. I understand that a $50 service fee will be added to all checks returned by my bank. If my account is sent to collections, a 50% collection fee will be added to my balance.

I have reviewed the above Policies and Procedures for Counseling. I agree to the terms listed in this document. Signature (client or guardian of minor) _____

Date _____

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8080 Ward Parkway, Suite 330
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Client name_____

LIMITATIONS OF CONFIDENTIALITY

There are limits to client confidentiality. Certain circumstances necessitate disclosure of confidential information by your therapist. Your therapist will be required to disclose confidential information if any of the following conditions exits:

1.You are a danger to yourself or someone else.

2. You seek treatment to avoid rightful detection or apprehension by legal authorities or to enable anyone to commit a crime.

3. Your therapist was appointed by the courts to evaluate you.

4. Your contact is for the purpose of determining competence.

5. Your contact is one in which your therapist must file a report to a public employer or to supply information required to be recorded in a public office, if such a report is open to public inspection.

6. You are under the age of 16 years and a victim of a crime.

7. You are a minor and your therapist reasonably suspects you are a victim of child abuse, including emotional, physical, or sexual abuse.

8. You are over 16 and you reveal yourself to be a perpetrator of child or elder abuse, including emotional, physical, and sexual abuse.

9. You are 65 or older and your therapist believes you are the victim of elder abuse, including emotional, physical, and sexual abuse.

10. You die and the communication is important to decide an issue concerning deed or conveyance, will or other writing executed by you.

11. You file suit against your therapist for breach of duty, or your therapist files suit against you for any reason.

12. You have filed suit against anyone and have claimed emotional or mental damages as part of the suit.

13. You waive your right to privilege or give consent to limited disclosure by your therapist.

14. Your insurance company is paying for your services and requests information from your file.

I have reviewed the above Limitations to Confidentiality. I agree to the terms listed in this document.

Signature (client or guardian of minor) _____Date