Tina C. Christian
LPC, NCC, TF-CBT Trained
Counseling & Coaching Services
"Because There Does Come A Time"
Tina@ATime2Talk.org
www.ATime2Talk.org

PO BOX 16741
RAYTOWN, MO 64133
(816) 873-1YOU (1968)

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

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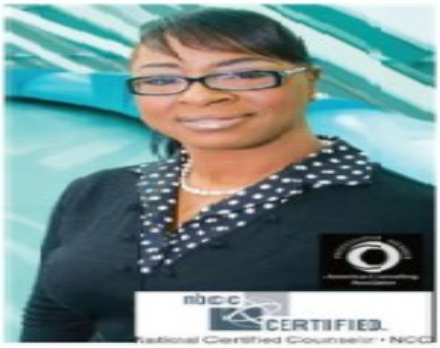

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

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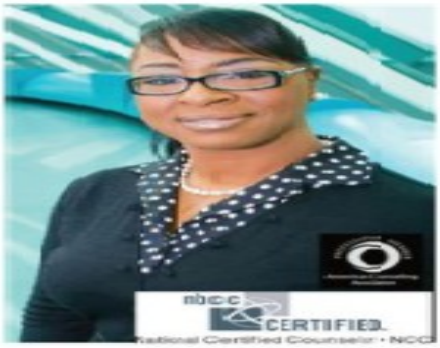

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Informed Consent for Psychotherapy

This form is required for your file

Introduction: A General Description of Psychotherapy, Risks, and Benefits

Psychotherapy is an intentional and goal-directed relationship with a professional therapist, and has been shown to be beneficial for individuals who fully engage in the process. Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, and increased skills for managing stress and resolutions to specific problems; however, there are no guarantees that this will happen. The process of psychotherapy often involves discussing unpleasant aspects of your life, and you may, to some degree, experience uncomfortable or negative feelings. If you feel this, please let your therapist know.

Therapists and Therapeutic Approaches

Tina C. Christian, LPC, NCC is a Licensed Professional counselor in the state of Missouri and a Nationally Certified Counselor with the National Board of Certified Counselors. **Tina C. Christian, LPC, NCC** uses a variety of interventions from many different approaches, including, but not limited to, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), Rational Emotive Therapy (REBT), Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy, Family Systems Therapy, Psycho-Education, Solution Focused Therapy (SFT), Brief Strategic Family Therapy (BSFT), and Parent-Management Training. Please discuss with your therapist any questions you may have about her approach. If you are unhappy with the services you are receiving, you feel free to share your comments or concerns, without fear of jeopardizing therapeutic relationship. This is **YOUR** therapy and you should feel safe and comfortable expressing any feelings regarding treatment at all times.

Initial Assessment, Termination of Treatment, and Referral to Others

Tina C. Christian, LPC, NCC will complete an initial intake assessment that will involve getting to know you by gathering relevant information about your background and your presenting concerns. After gathering this information, treatment options will be discussed. If **Tina C. Christian, LPC, NCC** believes she can be of assistance to you, she will recommend continuing to work together and will engage you in treatment planning. If she believes that she is likely not going to be able to be helpful, she will refer you to other clinicians she thinks would be effective. If at any point, she believes she is not effective in assisting you, she is ethically obligated to terminate treatment and refer you to other providers. All clients have the right to terminate treatment at any time, for any reason. If you make this choice, **Tina C. Christian, LPC, NCC** will provide you with the names of other qualified professionals or will direct you back to your insurance carrier to identify other providers. Finally, if you disengage in the therapeutic process (i.e., fail to schedule or attend appointments; do not respond to your therapist's attempts to reach you), **Tina C. Christian, LPC, NCC** reserves the right to close your file. At that time, you may be informed by mail that your file is closed.

Confidentiality

Information shared within the context of the therapeutic relationship will be held in confidence and will not be released without your written consent, except for professional consultation if needed and unless required by law. **Tina C. Christian, LPC, NCC** is required to break confidentiality if she suspects child or elder abuse or neglect. Additionally, if there are threats of harm to self (i.e., suicide) or others (i.e., homicide), then she is obligated to break confidentiality. If you are involved in court proceedings and a judge issues a court order for your records, **Tina C. Christian, LPC, NCC** may be required to release this information. Information regarding treatment and diagnosis will be provided to

your insurance company if you are utilizing insurance.
Tina C. Christian, LPC, NCC work toward engaging caregivers in the treatment of their clients as much as possible when clinically indicated. Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records, and do have a right to know their child's diagnosis, the dates, time, and duration of sessions, the types of treatment provided and the aftercare plan at the time of termination of services.

Client/Responsible Party Acknowledgment and Acceptance of Terms
I understand that this agreement is valid during the time that I am participating in services with **Tina C. Christian, LPC, NCC** . I have read, understand, and agree with this document's content and have been offered a copy of the Informed Consent for Psychotherapy. I acknowledge that I have had an opportunity to have my questions answered prior to signing this consent and participating in services. I am aware that I can stop therapy at any time.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian/Representative Date
(Required for clients 17 years old or younger)

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EMERGENCY COVERAGE:

My office is equipped with voicemail, which I frequently check throughout the day and evening for updated messages. I will make every reasonable attempt to respond to all messages within the same day, but it may be up to 24 hours before I return your call.

If you are in a "mental health emergency," in which you are in need of an immediate therapeutic response, please contact the CommCare's Access Community Hotline, at 1-888-279-8188. Inform the responding clinician of your immediate mental health needs, and follow their responses. Please inform the emergency clinician of your current status as a client enrolled in treatment with me, and sign any consents provided so that I may receive information regarding any emergency assessments &/or treatment recommendations.

In the event that I am not available for more than 48 hours, I will provide a "covering clinician," who will be available to respond to your emergency needs, either by telephone or with a face-to-face session. The clinician will be provided with a Coordination of Client Care Index Card that includes your first name and very basic potential clinical emergency information, so that he/she may appropriately and sensitively assist you in my absence. This information will be discussed with you prior to my absence. Upon my return, the "covering clinician" will inform me of any contacts (telephone or face-to-face session), and will then destroy any materials &/or information obtained in my absence. Any fees which may be charged by the covering clinician will also be discussed with you in advance."

_____

Client Signature (Client's Parent/Guardian if under 18)

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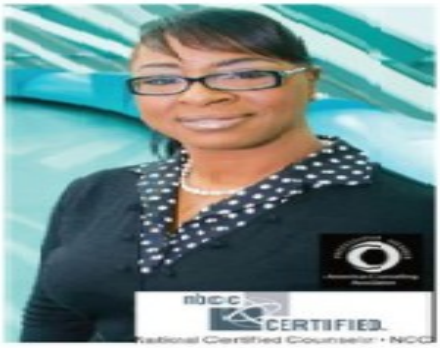

Email and Social Media Policy and Consent

Email Policy

My email address is: tina@atime2talk.org.

Clients are welcome to email me with scheduling questions or other concerns. Because the privacy of email cannot be guaranteed, I encourage clients to consider other methods for communicating sensitive information. I do return phone calls as promptly as possible. Because I may not see an email notification promptly, please do not use email to notify me of an emergency. If you are in crisis, please leave an urgent message at 816-873-1968. If you have a medical emergency, please go to a hospital or call 911.

I frequently come across information that may be pertinent to a particular client's issues. Clients are welcome to provide me an email address with permission to contact them, and I will send links to useful information as I come across it. This information is not intended to be diagnostic or as treatment, but simply as an educational adjunct to the therapy process.

Social Media Policy

Because I want to share resources and helpful mental health information with as many people as possible, I do maintain a page on Facebook. This is a public page, without any of the privacy settings that are available to individuals. I use this page to share resources, and answer questions if they are appropriate for a public forum. Clients may browse this page without "liking" it. However, if you choose to "like" the page, please make sure that you are fully aware of the level of sharing and privacy that you have enabled on Facebook. The settings for the page include a publicly visible list of those who have "liked" it. I do not "friend" clients on Facebook because I believe that puts us at risk of forming a dual-role relationship, which is prohibited by my ethical guidelines.

While I use the Facebook page primarily to share information, I also maintain both a Twitter account and a LinkedIn profile. These tools provide me outlets to share information, and a way for me to network with professional colleagues. My Twitter account is a publicly shared account, so anything posted on my Twitter feed is public information. I do not answer questions via Twitter because of its public status. Please use email or telephone for questions. I do not follow clients on Twitter, and I don't encourage clients to follow me, although if you choose to do so, be aware that the account is public, and your name would be listed in my "Followers" list. I do not connect with clients through my LinkedIn profile, because that is also a public forum.

My primary concern is that my clients' privacy be as protected as possible. Any connection through social media presents a possible compromise of that privacy, so I do not encourage clients to do so.

Please contact me directly with any questions or concerns.

Please sign and date below to indicate that you have read and understood these policies:

_____ _____

Signature Date

If you wish to receive my periodical newsletter, or educational information by email, please provide your email address:

_____

FINANCIAL POLICY

Tina C. Christian, LPC, NCC

Initial Intake Assessment	**$115.00**
Individual 30 minutes	**$55.00**
Individual 45 minutes	**$75.00**
Individual 53+ minutes	**$110.00**
Couples 53+ minutes	**$90.00**
Family 53+ minutes	**$90.00**
Crisis 60 minutes	**$115.00**
Smoking cessation counseling for symptomatic patient 3-10 minutes	**$15.00**
Smoking cessation counseling for symptomatic patient greater than 10 minutes	**$20.00**
Alcohol and/or substance abuse structured screening & brief intervention services; 15 to 30 minutes	**$53.00**
Alcohol and/or substance abuse structured screening & brief intervention services; greater than 30 minutes	**$101.00**
Alcohol and/or substance abuse structured screening & brief intervention services; greater than 45 minutes	**$149.00**
Alcohol and/or substance abuse structured screening & brief intervention services; 90 minutes	**$200.00**
Support Groups / Group Therapy	**$45.00**
Workshops	**varies**
Coaching Service 45 minutes	**$65.00**
Coaching Monthly	**$195.00**
Coaching Quarterly	**$525.00**
Coaching Semi-Annual	**$1,050.00**
Coaching Annual	**$1,815.00**
ESA - First regular letter to either an airline, landlord or university	**$85.00**
Additional ESA letter to either an airline, landlord, or university	**$10.00**
1 Additional Pet	**$5.00**
2nd Additonal Pet	**$10.00**
Verification Form if rquired by landlord or airline (per form)	**$25.00**

FINANCIAL POLICY

Tina C. Christian, LPC, NCC

I understand that the acceptable payments are American Express, Discover, Health Savings Account, MasterCard, PayPal, and Visa.

I understand that the therapist is not in network with any insurance companies other than Medicaid and United Healthcare, so ALL services for individual with other insurance companies are strictly client pay services, which MAY be eligible for reimbursement by the my insurance company, based upon the insurance online counseling and or out-of-network policy/coverage.

I understand that If I have a Preferred Provider Organization (PPO) Plan, I MAY be able to be reimbursed for out-of-network services, and that I will be given Superbill with required information to submit to my insurance company for reimbursement upon my request.

I understand that I may receive a percentage of the customary rate of counseling determined by my insurance company (minus my co-pay), reimbursed to me.

I understand that Health Maintenance Organization (HMO) plan clients will NOT receive any reimbursement from the insurance companies for out-of-network sessions.

I understand that the therapist cannot assume responsibility for interpreting my insurance policy or for my specific insurance coverage.

I understand that it is my responsibility to check with my insurance plan policy or contact my insurance company to confirm my online counseling and or out-of-network coverage (co-pays, fees, deductibles, and reimbursement eligibility).

I understand that all payments are due prior to service rendered.

I understand that all billing and administrative data is secured.

PRIVACY

I understand that for the purpose of the collection, use and disclosure of my personal information is for the provision of professional counseling, including supervision for the purposes of improving provision of such counseling services. Only my therapist and my therapist's supervisor have complete access to my records while they are in the therapist's custody. Administrative staff cannot access my therapy records, but may have access to general account information.

ALTERNATIVE METHODS OF PAYMENT

I understand that if I do not have insurance, don't have out-of-network insurance coverage, or if by chance I am in need of assistance and/or interested in receiving reduced face-to-face rates, I may inquire about enrolling with Open Path Psychotherapy Collective to apply to receive therapy at a steeply reduced rate, available through the program to individuals in need. I understand that Open Path allows my therapist to offer mental health care-sessions at a reduced rate of $30 - $80 per session to a limited number of clients. **OpenPath is not an available service for ESA service only.**

I understand that if I qualify, a sliding scale fee can be applied. **Sliding fee is not an available service for ESA service only.**

FINANCIAL POLICY

Tina C. Christian, LPC, NCC

SLIDING FEE SCALE

1. No health insurance coverage for mental health outpatient services.
2. Medicare
3. Any insurance which will not pay mental health/out-of-network benefits.
4. Income (from employment, disability, or otherwise) below $30,000 per year.
5. Within the last 6 months, discharged from an in-patient psychiatric hospitalization or long-term medical care.
6. Unemployed for at least 6 months or have never been employed.
7. Currently on some form of public assistance or social security/disability.
8. A single mother or father.
9. A full time student.

If qualified, the sliding scale fee will be determined prior to or during your initial assessment and will be based upon the criteria met above.

Should your financial situation change, your fee will be reassessed and it is your responsibility to notify us of any changes.

I understand that my signature below indicates my understanding of, and agreement with, the policies outlined above, and my agreement to pay my therapist for services rendered.

INITIAL PHONE CONSULTATION

I understand that upon request, prior to scheduling an appointment, all potential clients are offered an initial phone consultation.

PHONE CONSULTATION/SESSIONS

I understand that live phone consultations are scheduled.

ELECTRONIC COMMUNICATION

I understand that some insurance carriers will may not cover electronic communications at this time.

CANCELLATION POLICY

I understand that I may still be responsible for paying my therapist for missed or cancellations of a scheduled appointment with less than a 24 hours notice unless it is due to illness or an emergency. Therapist will make every effort to reschedule any properly scheduled sessions.

I understand that my insurance does not cover such charges.

I understand that if I fail to cancel a scheduled appointment, therapist cannot use this time for another client and I will be billed for the entire cost of my missed appointment.

Please note that with ESA letter service, you are paying to be assessed using client intake diagnostic and evaluation assessment, and counseling sessions with Tina C. Christian, LPC, NCC. Once you have completed the assessment and spoken to Tina C. Christian, LPC, NCC, refund for services will not be warranted.

Rates Effective 09/27/2018 - (Please note that rates are subject to change with a 30 day notice.)

_____ _____

Finacially Responsible Party Signature **Date**

INTAKE INFORMATION

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Client Name: _____ Date: _____
(First, Middle and Last)

DOB: _____ Age: _____ Gender □ Male □ Female Race:_____

Parent(s)/Guardian (if minor): Mom) _____ (Dad)_____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( )_____ May we leave a message? □ Yes □ No

Cell/Other Phone:( )_____ May we leave a message? □ Yes □ No

Cell Carrier Name: _____

E-mail: _____ May we email you? □ Yes □ No

(Please note: E-mail correspondence is not considered to be a confidential medium of communication)

Emergency Contact Name: _____ Relationship to Contact: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION (if applicable)

Primary Insurance Company: _____ Policy ID #_____

Group No.: _____ Plan Name: _____ Insured's Employer/School _____

Policy Holder's Name: _____Policy Holder's Date of Birth: / /

Policy Holder's Address: _____ City: _____ State: ____ Zip: _____

Secondary Insurance Company: _____ Policy ID #_____

Group No.: _____ Plan Name: _____ Insured's Employer/School _____

Policy Holder's Name: _____Policy Holder's Date of Birth: / /

Policy Holder's Address: _____ City: _____ State: ____ Zip: _____

Please Note: Please have your insurance card(s) or a copy of the card(s) with you for your first appointment.

1. Reason for treatment? (Self-referral, CD, other agency, etc...)

   _____

2. Presenting concerns, issues, problem, and or behaviors?

   _____

3. Greatest Challenge: _____ Greatest Achievement: _____
4. Has there been any history of hospitalizations for mental illness; criminal activity; or substance use?

   _____

5. Client's Employment Place and (FT/PT)? _____Employment: Satisfactory Unsatisfactory
6. Other sources of income: _____ Finances: Satisfactory Unsatisfactory
7. Client's Education level? _____
8. Marital status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed
9. Siblings/children names and age? Names: _____
10. Please list any other family members living in the same household: _____
11. Please list other unrelated people living in the same household: _____
12. Client close relationships?_____

HEALTH AND MENTAL HEALTH INFORMATION

13. How would you rate your current physical health? (circle)

    Poor Unsatisfactory Satisfactory Good Very Good

14. Please list any specific health problems you are currently experiencing:

    _____

15. How would you rate your current sleeping habits? (circle)

    Poor Unsatisfactory Satisfactory Good Very Good

16. Please list any specific sleep problems you are currently experiencing:

    _____

17. How many times per week do you/your child generally exercise? _____

18. What types of exercise do you participate in? _____

19. Please list any difficulties you experience with your appetite or eating patterns:

    _____

20. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

    If yes, approximately how long? _____

21. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

    If yes, when did you begin experiencing this? _____

22. Are you currently experiencing any chronic pain? ☐ Yes ☐ No

    If yes, please describe: _____

23. Any history of Domestic Violence? (Individual or Family) ☐ Yes ☐ No If yes, please describe:

    _____

24. Any history of emotional abuse? (Individual or Family) ☐ Yes ☐ No If yes, please describe:

    _____

25. Any history of physical abuse? (Individual or Family) ☐ Yes ☐ No If yes, please describe:

    _____

26. Any history of sexual abuse? (Individual or Family) ☐ Yes ☐ No If yes, please describe:

    _____

27. Any History of Suicidal ideation or attempts of suicide (Individual or Family) ☐ Yes ☐ No If yes, please describe:

    _____

28. Any history of homicidal ideations? ☐ Yes ☐ No If yes, please describe:

    _____

29. Any history of cruelty to animals? ☐ Yes ☐ No If yes, please describe:

    _____

30. Any history of fire starting? ☐ Yes ☐ No If yes, please describe:

    _____

31. Any history of Substance use or abuse? (Individual or Family and current status) ☐ Yes ☐ No If yes, please describe:

    _____

32. Any history of anger management? (Individual or Family) ☐ Yes ☐ No If yes, please describe:

    _____

33. Any history of trauma or traumatic events? ☐ Yes ☐ No

    _____

34. Any problems with complying with directives ? ☐ Yes ☐ No

35. Any positive peer relationships? ☐ Yes ☐ No If so, how many? _____ Frequency of peer interactions? _____

36. Ability making and keeping friendships? ☐ Yes ☐ No

37. Community activities or involvement? ☐ Yes ☐ No If yes, please list: _____

_____

38. Developmental milestones? Premature? Alcohol or drug exposed? ☐ Yes ☐ No If yes, please describe:

_____

39. Grade level completed? _____ IQ? _____ Learning disabilities or advanced? If yes, please describe:

_____

40. Three Triggers? _____How do you relax? _____

41. Current of past health/medical issues? _☐ Yes ☐ No If yes, please list:

_____

42. Last medical exam/physical? _____ Was hearing and vision included? If, not hearing and vision last exam date? _____ Last dental exam? _____

43. Any hospitalization for injuries of elements? ☐ Yes ☐ No If so, when?_____

44. Current MH TX: _____ Prior MH TX/HX:_____

45. Any prescription medications? ☐ Yes ☐ No If yes, please list:

Medication Name: _____ How Long? _____ Dosage and Frequency? _____

Medication Name: _____ How Long? _____ Dosage and Frequency? _____

46. Ever been prescribed psychiatric medication? ☐ Yes ☐ No If yes, please list and provide dates:

Medication Name: _____ Dates: _____ to _____

Medication Name: _____ Dates: _____ to _____

47. Any known allergies including foods and medicines? ☐ Yes ☐ No If yes, please list: _____

_____

48. Church involvement? ☐ Yes ☐ No Religion?_____

49. Legal and or criminal history (client/family) offenses? Dates? Sentences/penalties? ☐ Yes ☐ No If yes, please list:_____

50. Expected outcome for therapy?

_____

51. Hopes/dream? _____ Values? _____

Talents?_____ Family Traditions?_____

Hobbies/Interest? _____ Do for fun?_____

52. Supports and involvement (family, spiritual, social, mental, professional, other agencies):

_____

53. Housing: Poor Unsatisfactory Satisfactory Good Very Good

54. Any Financial stressors? ☐ Yes ☐ No If yes, please list: _____

55. Good problem solving and decision making skills and ability? ☐ Yes ☐ No

56. Strengths: _____ Weakness: _____

57. Please provide the name, address and phone number for you Primary Physician:

Name: _____ Address: _____ Phone: _____

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.