Margaret A. Lucas, LLC

General Patient Information

Date: ________________________________

Name: _________________________________ Date of Birth: ________________

Responsible Party, if different from above: _____________________________________

Employer: ____

Patient Address: ____
Street

____
City State Zip

Phone Numbers: ____
Home Cell

May I leave a voice message on an answering machine or with anyone who answers?

_________ Yes ________ No

Email Address: ____

Who referred you (Physician, friend, internet): _________________________________

In case of an emergency, who should I contact?

Name: ____________________________________
Relationship: ____________________________Phone Number: _____________________________

Consent to Text Message Use for Appointment Reminders

I understand that text messages are generally not secure because they are not encrypted, and wireless carriers may store the text messages. Margaret A. Lucas, LLC will only send appointment reminders and general information by text and does not send any texts containing protected health information. I understand and acknowledge that if I send any texts containing protected health information to Margaret A. Lucas, LLC, the confidentiality and security of that information cannot be assured.

I understand that upon receipt of my request to revoke this Consent, Margaret A. Lucas, LLC will discontinue sending me appointment reminders by text.

I have read the above information and consent to receive appointment reminders by text message to the cell phone number I provided above:

_________ Yes ________No Patient Signature: ____

(revised 11/01/2018)

Margaret A. Lucas, LLC

History Information

Completing the following information as thoroughly as possible will help your therapist provide you the best treatment.

Who is providing the history information? [ ] The patient [ ] The patient's guardian
[ ] Other: ________________________

Please describe the current complaint or problem or reason for appointment as specifically as you can, in your own words:

____

____

How long have you experienced this problem, or when did you first notice it? ______________________

What stressors may have contributed to the current complaint or problem?

____

____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Depression/sad/down____
[ ] High/Low energy level ____
[ ] Angry/Irritable ____
[ ] Loss of interest in activities ____
[ ] Difficulty enjoying things ____
[ ] Crying spells ____
[ ] Decreased motivation ____
[ ] Withdrawing from people ____
[ ] Mood Swings ____
[ ]Change in weight or appetite ____
[ ]Suicidal thoughts or plans ____
[ ] Poor concentration ____
[ ] Feelings of hopelessness ____
[ ] Feelings of shame or guilt ____
[ ] Feelings of being cheated ____
[ ] Feelings of inadequacy ____
[ ] Anxious/nervous/tense ____
[ ] Panic attacks ____
[ ] Racing or scrambled thoughts ____
[ ] Bad or unwanted thoughts ____
[ ] Flashbacks ____
[ ] Muscle tensions, aches, etc. ____
[ ] Hearing voices ____
[ ] Seeing things ____
[ ] Thoughts of hurting people ____

[ ] Thoughts of running away ____
[ ] People are out to get me or hurt me ______________________________________
[ ] Feelings of frustration ____
[ ] Indecisiveness about career ____
[ ] Job problems ____
[ ] Sleep problems:____

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No
Have you in the past experienced thoughts of harming either yourself or some one else? [ ] Yes [ ] No

Treatment History

Previous Outpatient counseling and/or psychotherapy? [ ] Yes [ ] No
Additional Information: ____
Previous Psychiatric hospital admissions? [ ] Yes [ ] No
Additional Information:____
Previous Chemical dependency admissions: [ ] Yes [ ] No
Additional Information:____
Suicide attempts: [ ] Yes [ ] No How & When? ____________________________________

List any current, or past, medications

Medication & Dose	Date	Response
______________________	__________	________________
______________________	__________	________________
______________________	__________	________________

Family History of Emotional Problems

Are you aware of a family history of emotional problems _______ Yes _______No
If yes, who ____

Medical History

History of serious childhood illnesses: ____
Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: ____
Have you experienced any head injuries? [ ] Yes [ ] No Important Details: _________________
If yes, did you lose consciousness? [ ] Yes [ ] No
Have you experienced convulsions or seizures? [ ] Yes [ ] No If yes, did you also have a fever?
[ ] Yes [ ] No
Allergies: [ ] None [ ] Allergic to :____

(revised 11/01/2018)

How would you rate your current physical health? [ ] Excellent [ ] Very Good [ ] Good
[ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health "check up?" ___________________________

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes [ ] No Additional Information:

____ ____

Have you ever tried to cut down on your drinking or drug? [ ] Yes [ ] No
Are you annoyed when people ask you about your drinking or drug use? [ ] Yes [ ] No
Do you ever feel guilty about your drinking or drug use? [ ] Yes [ ] No
Do you ever take a morning eye-opener of drink or drug? [ ] Yes [ ] No

Additional Information

Summarize your goals for counseling/therapy:

____

____

____

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible?

____

____

_______________________________ _______________________________

Signature of patient or guardian Date

(revised 11/01/2018)

MARGARET A. LUCAS, LLC
INFORMED CONSENT AND PROFESSIONAL SERVICES AGREEMENT

About Margaret A. Lucas, LCAC, LCPC, LPC: Margaret A. Lucas is a licensed clinical addictions counselor (Ks license no. 285) and a licensed clinical professional counselor in the state of Kansas (Ks license no. 2396). Margaret A. Lucas is also a licensed professional counselor in the state of Missouri (Mo license 2016013353).

Counseling and Therapy Process: Counseling and psychotherapy require a great deal of participation and cooperation from you. Your effort will be important in determining how much benefit you will receive. Much of what occurs during a session is dialogue. You will be expected to relate not only problems and concerns, but successes as well. At times you may be given homework assignments such as reading, keeping a journal, monitoring your own behavior, practicing new behavior, etc. You may also be asked to complete some questionnaires and/or tests. It is important that you regularly and promptly attend scheduled sessions. No guarantees are made as to the result of treatments, assessments, or consultations.

Fees: You agree to pay at each session, or at some mutually agreed time, the amount per 45-50 minutes of service listed in your signed fee schedule, unless other arrangements are mutually contracted in writing (exs. health insurance, EAP). We will honor and abide by any contractual arrangement with EAPs or insurance plans in which we participate. Longer sessions and phone calls in excess of 15 minutes will be prorated on the basis of this amount. If you wish to pay for your therapy with your credit card, the system used will securely hold your information for future payments. I hold the right to discontinue treatment if payments have not been made on prior sessions.

Insurance Coverage: If insurance is used, your company will be charged the full rate per session listed in your signed fee schedule. Most insurance companies have a deductible and copayment (non-negotiable) that you are responsible to pay at the time services are rendered by me. Using insurance requires providing the insurance company with information relevant to the services rendered. This includes a clinical diagnosis and other protected health information. If you have insurance coverage that includes mental health benefits with an out of network counselor, there may be some reimbursement for you from your insurer. If this is the case, a bill will be provided to you to submit to your insurance. It typically takes about 30 to 60 days for reimbursement to be made to you. You understand that you, not your insurance company, are ultimately responsible for payment of all fees for services provided to you. Unless I am a participating provider in your health insurance, we will not file an insurance claim on your behalf.

Other Services: Some services are not typically covered by health insurance and may be an out-of-pocket expense for you. Examples include report writing, consultations, psychological testing, test interpretations, preparation of records, treatment summaries, court appearances, and school visits. Fees and payment schedules for other professional services will be contracted as they are needed. Legal proceedings that require my participation incur additional charges that are not typically covered by insurance. These include all my professional time, including preparation and transportation costs, even if I am called to testify by another party. Due to the difficulties of legal involvements, the charge for preparation and attendance at any legal proceeding is $240.00 per hour.

Late Cancellation and Missed Appointment Fees: Once an appointment is scheduled you will be expected to pay a $30 fee for cancellations not made with at least 24-hour notice. Cancellations due to inclement weather or other major emergencies will not incur a charge, however please contact me to inform of this. It is important to note that insurance companies do not provide reimbursement for late cancellation or missed appointment fees. Variance from this policy is at my discretion.

Phone Contact: It is preferable for you to bring your concerns to your regularly scheduled sessions; however, phone support is available to you and may be billed to you when in excess of 15 minutes, prorated at the hourly rate of your agreed to fee per your signed fee schedule. Insurance will not pay for phone sessions. I have confidential voice mail for emergency and non-emergency situations i.e., cancellations, rescheduling, and clinical updates. You understand that I am often not immediately available by telephone and there is no guarantee of my availability to you by phone. Outside of business office hours there is an Answering Service for clinical emergencies only. If you have a life-threatening emergency please call 911 or other appropriate authority, then contact the on-call service if additional support is needed. The Answering Service can be accessed by dialing 913-791-1298 and following the instructions.

Confidentiality and Client Rights: The Notice of Information and Privacy Practices provided to you contains information regarding HIPAA's confidentiality of your health information, our uses and disclosures of your health information, and your rights with respect to access, use and disclosure and are incorporated herein by reference. Professional records, including Protected Health Information and psychotherapy notes, are handled in accordance with HIPAA requirements. The laws governing confidentiality can be quite complex. In situations where specific legal advice to me is required, I reserve the right to seek legal advice.

Please be aware that if you choose to file insurance claims for your sessions, your confidentiality is affected, since insurance companies require a medical diagnosis for reimbursement purposes. In that case, only the minimum amount of information necessary is provided.

Consultations: It may be helpful for me to consult other health and mental health professionals about your case. During a consultation every effort will be made to avoid revealing your identity. Other professionals are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless the other professional believes that it is important to our work together. All consultations will be maintained as Protected Health Information.

Termination: If at any point during therapy I determine that I am not effective in helping you reach the therapeutic goals we have set or perceive you as non-compliant or non-responsive, and if you are available or it is appropriate to do, I will discuss the termination of treatment with you. If determined to be appropriate and/or necessary, I will provide you with referrals to qualified professionals whose services may be of help to you. If you request and authorize me to do so in writing, I will talk to the professional of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another mental health professional, I will provide you with referrals upon your request. You have the right to terminate therapy and communication with me at any time. If you choose to do so, upon your request and if appropriate and possible, I will provid you with names of other qualified professionals whose services you might prefer.

By signing below, I acknowledge that I have reviewed and understand the foregoing terms and conditions of services of Margaret A. Lucas, LLC. I consent to participate in treatment and agree to accept financial responsibility for full payment of the services I receive as set forth in the fee schedule or as otherwise stated in this Agreement.

______________________________	______________________________
Client Name (Printed)	**Authorized Signature**

____

Date

______________________________	______________________________
Client Name (Printed)	**Authorized Signature**

____

Date

(revised 11/01/2018)

Margaret A. Lucas, LLC

FEE SCHEDULE
50 minute sessions

Overland Park:

Saturdays:	$120
Weekday before 4:00pm	$ 90
Weekday 4:00pm and after	$120

Blue Springs:

Weekday before 5:00pm	$ 80
Weekday 5:00pm and after	$110

Therapist retains the right to adjust fees with notice.

By signing below, I acknowledge that I have read and understand this fee schedule and agree to accept financial responsibility for full payment of the services I receive.

______________________________ ________________________
Client Signature Date

______________________________ ________________________
Client Signature Date

I am in network with Tricare and Triwest. If you have one of these insurance plans, you have checked your benefits, and wish for me to file for payment of your fees for sessions with either of these insurance companies, please sign below:

______________________________ ________________________
Client Signature Date

(revised 11/01/2018)

Margaret A. Lucas, LLC

NOTICE OF INFORMATION AND PRIVACY PRACTICES

(Effective Date: November 1, 2018)

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

Your Rights under the Federal Privacy Standard

As a client of Margaret A. Lucas, LLC, you have the right to the confidentiality of your records and information regarding whether you currently are, or ever have been a patient. Although your mental health records are the physical property of Margaret A. Lucas, LLC, you have the following rights with regards to the information contained therein:

- **Right to Request Restrictions on Uses and Disclosures:** You have the right to request restriction on uses and disclosures of your health information for treatment, payment, and healthcare operations. The right to request restriction does not extend to uses or disclosures permitted or required under federal privacy regulations. Your request must be in writing. Your request must describe in detail the restriction you are requesting. We do not, however, have to agree to the restriction. If we do, we will adhere to it unless you request otherwise, or we give you advance notice.

- **Right to Request Restrictions on Disclosures to your Health Insurance Company:** You have the right to request restrictions on disclosures to your health insurance company for purposes of treatment or healthcare operations. We are required to agree to this restriction so long as you have paid for the underlying service in full. Your request must be in writing.

- **Right to Receive Copy of this Notice:** You have the right to receive a paper copy of this Notice of Information and Privacy Practices upon request. We also have made this Notice available on our website.

- **Right to Receive Confidential Communications.** You have the right to ask us to contact and communicate with you in a specific way or by alternate means, and if the method of communication is reasonable, we must grant the request. For example, you may not want a family member to know you are being seen for counseling. Upon your request, we will send your bills and other written communications to another address or only contact you at a specific phone number.

- **Right to Inspect and Copy Records:** You have the right to inspect and copy your health information and/or tell us where to send the information upon request. We will provide a copy or summary of your requested health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

This right does ***not*** include "Psychotherapy Notes" which are notes that have been written by your Counselor about the conversation during a private, group, joint or family counseling session that are maintained separate from your medical record. "Psychotherapy Notes" are not intended to communicate to, or even be seen by, any person other than your Counselor. We must have a specific authorization for the disclosure of Psychotherapy Notes.

In certain situations, we may deny access, but must also provide you a review of our decision. These "reviewable denials" include the following:

1) If in the exercise of my professional judgment, I have determined that the access is reasonably likely to endanger the life or physical safety or yourself or another person; **2)** the information makes reference to another person (other than a healthcare provider) and I have determined that access is likely to cause substantial harm to such other person; or **3)** the request is made by your personal representative and I have determined that giving access to the personal representative is reasonably likely to cause substantial harm to you or another person. For these reviewable grounds, another licensed professional must review my decision to deny access within 60 days. If I deny you access, I will explain why and what your rights are, including how to seek review. If I grant access, I will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable fee for making copies that may be requested following review.

In certain situations, we may deny access and you are not entitled to a review. These "unreviewable denials" include the following:

1) When access to psychotherapy notes are requested; and **2)** when information is compiled in reasonable anticipation of, or for the use, in a legal or administrative action or proceeding; when someone other than a health care provider provides information about you under a promise of confidentiality and the access to the requested information would be reasonably likely to reveal the source of the information.

- **Right to Revoke an Authorization.** You may also revoke an authorization for use or disclosure at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that **1)** we have already taken action in reliance on that authorization; or **2)** if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

- **Right to Amend Your Health Information:** You have the right to request an amendment or correction of your health information. We do not have to grant the request if the following conditions exist: **1)** we did not create the record; **2)** the records are not available to you as discussed above; and **3)** the record is already accurate and complete. If we deny your request for amendment or correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction as allowed.

- **Right to an Accounting of Disclosures:** You have the right to obtain an accounting of non-routine uses and disclosures, those other than for treatment, payment, and healthcare operations. We do not need to provide an accounting for the following disclosures: **1)** to you for disclosures of protected health information to you; **2)** for uses and disclosures that you authorized; **3)** to persons involved in your care or for other notification purposes as allowed in the federal privacy regulations; **4)** for national security or intelligence purposes as allowed under the federal privacy regulations; **5)** to correctional institutions or law enforcement officials as allowed under the federal privacy regulations; **6)** that occurred before April 14, 2003. We must provide the accounting within 60 days, and the accounting must include the following information: **1)** date of each disclosure; **2)** name and address of the organization or person who received the information; **3)** brief description of the information disclosed; **4)** brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, a copy of your written authorization or written request for the disclosure.

- **Right to be Notified of a Breach:** You have the right to be notified if we determine that there has been a breach of your protected health information.

- **Right to file a Complaint:** You have the right to file a complaint with Margaret A. Lucas, LLC or the U.S. Department of Health and Human Services if you believe Margaret A. Lucas, LLC is not in compliance with the regulations.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights as detailed above, the federal privacy standard requires us to take the following measures:

- We will maintain the privacy of your health information, including implementing reasonable and appropriate safeguards to protect the information.
- We will provide you this notice as to our legal duties and privacy practices with respect to the information that we collect and maintain about you.
- We will abide by the terms of this notice that is currently in effect.
- We will mitigate (lessen the harm of) any breach of privacy or confidentiality.
- We will use or disclose your health information ***only*** with your individual consent or authorization, ***except*** as described in this notice or as allowed by law.

In the following circumstances, we may use or disclose your health information ***without*** your consent or authorization:

Treatment. To share information and communicate between or among treatment providers and facilities for the purposes of promoting the provision, coordination, or management of health care and related services by one or more health care providers.
Health Care Operations. Utilizing health information for health care operations including quality assessment activities, auditing functions and legal services, business management and general administrative activities of Margaret A. Lucas, LLC.
Child abuse. If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, or is otherwise in need of protective services, I must report the matter to the appropriate authorities.
Adult and Domestic Abuse. If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
Health Oversight Activities. I may disclose health information to the Kansas Behavioral Sciences Regulatory Board or to the State of Missouri Committee for Professional Counselors if necessary for an investigation or proceeding before the Board, or to other government agencies authorized by law to oversee health care and have access to the information.
Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records of your treatment, I will only disclose your privileged information upon your or your legally-appointed representative's authorization, or a court order or other valid legal process. However, the privilege does not apply when you are being evaluated for a third party or a court has ordered your evaluation. You will be informed in advance if this is the case.
Defense of a Lawsuit. I may disclose your confidential information if I am defending myself in a lawsuit brought against me by you.
Serious Threat to Health or Safety. If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. Additionally, if I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
Worker's Compensation. I may disclose your health information as authorized by and to the extent necessary to comply with laws relating to worker's compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

Examples of How We Use and Disclosure Your Health Information for Treatment, Payment, or Healthcare Operations

Treatment is defined as the provision, coordination, or management of health care and related services by one or more health care providers. This includes the exchange of information in professional consultation and supervision among other health care providers. An example of a disclosure for treatment would be when I consult with another health care provider about your condition, such as your family physician or another mental health provider.

Payment is defined as the activities undertaken by a health care provider to obtain reimbursement for the provision of health care. This may include sharing of necessary information necessary to determine eligibility, or coverage and obtain reimbursement for services. An example would be when I send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, or treatment received. *If you elect to not use your insurance coverage, DO NOT give permission for your insurance company or other payor to have access to your health information and records.*

Healthcare Operations is defined as carrying out the activities related to the performance and operations of our practice. Examples include Quality Assurance and improvement activities; and business-related matters such as audits, legal services, and administrative services.

Margaret A. Lucas, LLC may provide health information through contracts with Business Associates. This information may be disclosed to the business associate so that they can perform the function(s) that we have contracted with them to do. An example of a business associate would be our electronic medical record software provider. Our business associates have all the same responsibilities to appropriately safeguard your information as Margaret A. Lucas, LLC does.

Additional Activities: Margaret A. Lucas, LLC may contact you or your parent/guardian (if applicable) by phone call or mail in the following situations: **1)** to provide appointment reminders and other information regarding services; **2)** to notify you of the discontinuation of therapy services when we have not had contact with you for an extended period of time; and **3)** to request additional information and/or signatures in order to facilitate payment of your account. We may also send you appointment reminders by text message if you specifically agree.

Revisions Made to this Notice

Margaret A. Lucas, LLC reserves the right to change the terms of its Notice of Information and Privacy Practices, and to make the new notice provisions effective for all protected health information that it maintains. Revised notices will be made available to clients at their first service following implementation of the revision, posted at each practice location, and made available on our website.

How to Complain

If you believe your privacy rights have been violated, you may complain to Margaret A. Lucas, LLC, by contacting Margaret A. Lucas at 816-463-2604, or the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. Specific contact information and the requirements for filing a complaint with OCR may be obtained on: https://www.hhs.gov/hipaa/filing-a-complaint/index.html The complaint should be filed within 180 days of when the complainant knew or should have known that the act or omission occurred. You may also ask Margaret A. Lucas for more information on how to file a complaint with OCR. Individuals will not be retaliated against for filing such a complaint.

More Information

If you would like more information about this Notice of Information and Privacy Practices, please contact Margaret A. Lucas at 816-463-2604.

Margaret A. Lucas, LLC

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Margaret A. Lucas, LLC's Notice of Information and Privacy Practices effective November 1, 2018. I am aware the Notice is available at: http://www.lucascounseling.com/contact.html and that I may request and receive a copy at any time.

Name (please print): ____________________________________

Signature: ____________________________________

Date: ____________________________________

I am a parent or legal guardian of _______________________ (child's name). I have received a copy of Margaret A. Lucas, LLC's Notice of Information and Privacy Practices effective

Name (please print): ____________________________________

Relationship to Patient: Parent Legal Guardian

Signature: _____________________________________

Date: _____________________________________

Staff Only:

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 11/01/18 given to individual on _______________ (date)

In Person Mail *Email Other ______________________

Reason individual or parent/legal guardian did not sign this form:

Did not want to Did not respond after more than one attempt Other _________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

In person conversation ______________________________________
Telephone contact ____
Mailing ____
*Email ____
Other ____

Staff Name (please print): ________________________________ Title: ______________

Signature: ___________________________________ Date: ________________________

****Use of email first requires client consent to receive communications through electronic transmissions.***

(revised 11/01/2018)