# Betty Kratzenberg, MS, LMFT

INITIAL CLIENT INFORMATION

**Client Information:**

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

Okay to call or leave message at: home: ☐Yes ☐No work: ☐Yes ☐No

SS#_____ DOB_____ Age_____ Gender ____M ____F

Would you like me to contact your Primary Physician? ☐Yes ☐No Name:_____ Phone:_____

Are you currently seeing a psychiatrist? ☐Yes ☐No Name:_____ Phone:_____

**Emergency Contact**_____**Phone No.**_____

**Responsible Party Information:**

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

SS#_____ DOB_____ Relationship to Client _____

**Primary Insurance Information:**

Ins. Co._____ Plan Name_____

Policy #_____ID#_____Group #_____

Deductible $_____ Copay Amount $_____

**Insured's Employer**_____Relationship to client ☐Self ☐Spouse ☐Parent ☐Other

**Insured's Name**_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ SS#_____ DOB_____

**Information Below For Office Use Only:**

Clinician: Betty Kratzenberg, MS, LMFT Initial Appt_____/_____/_____ Visits per year_____Other_____

Dt of auth_____/_____/_____ To_____/_____/_____ Authorization #_____

CPT Code/Allowed: 90801____ 90806_____ 90847_____ Other_____

Claims address_____

**DX:** Axis I_____Axis II_____Axis III_____Axis IV_____

Axis V: Pre_____ Post _____ Presenting Problem_____

# Betty Kratzenberg, MS, LMFT

OFFICE POLICIES

After reading each section, please initial that you have read and understood the information. Feel free to ask questions if something is not clear and do not hesitate to raise any concerns regarding this information with your counselor.

**CONFIDENTIALITY** _____ (initial)

When seeking psychological services, you have the right to expect that issues discussed during the course of individual psychotherapy will be kept confidential. Confidentiality means that your personal/private information will not be shared with others, since counselor/client communication is protected by law ("Privileged").

There are times however, when we believe that exchanging or receiving important information from others (e.g., doctors, teachers, etc.) allows us to better serve your psychological needs and provide a higher quality of care. Therefore, with your agreement, you may waive the privilege of confidentiality by providing your written permission on a Release of Information form. Once you sign a "release" form, you may withdraw your consent at any time. Please read the Notice of Privacy Practices guide provided to you.

**EXCEPTIONS TO CONFIDENTIALITY** _____ (initial)

There are several possible exceptions to confidentiality:

1. *Danger to self and/or others:*
   a. If there is reason to believe that you are a serious danger to yourself or others, your counselor must take steps to reduce the risk.

2. *Insurance Reimbursement:*
   a. If insurance reimbursement is arranged, insurance companies reserve a right to have another professional review the case.
   b. Many insurers require periodic therapy summaries called Outpatient Treatment Reports (OTR) before they will authorize additional reimbursement.
   c. Information included on the insurance claim form is no longer considered confidential.

3. *Court Orders*
   a. There are cases where courts have ordered the release of otherwise privileged records, such as in certain child custody cases where judges have ruled that the well being of the child outweighs the parent's privilege of confidentiality.
   b. If you are involved in a criminal case, your records can be subpoenaed.

**EMERGENCIES/LIMITS OF SERVICE** _____ (initial)

If you have a clinical emergency, you may contact your counselor via the office's voicemail notification service. If your counselor is not available, you are advised to go to an emergency room or contact the local crisis hotline.

**APPOINTMENTS** _____ (initial)

Counseling appointments are typically scheduled for 50 minutes. You and your counselor will arrange the frequency of appointments that best suits your needs. Your insurance company may only allow for a specific number and frequency of appointments (e.g., every two weeks.) Should you wish to make a change in the frequency of appointments, please discuss it with your counselor.

**CANCELLATIONS AND MISSED APPOINTMENTS** _____ (initial)
Canceled appointments will be accepted up to **24 hours prior** to the time of the appointment without a fee incurred. Therefore, if you need to cancel or change your appointment for any reason, please call to do so at the earliest possible time.

Since appointment times are held exclusively for you, late cancellations or missed appointments are "lost time" which might have been utilized by someone else. Therefore, cancellations with **less than 24 hours prior notice** to the appointment, or missed appointments, will result in a $50 fee billed directly to you and payable on or before the next scheduled appointment. **Any additional late cancelations or missed appointments will be billed to you for the full fee you and/or your insurance pay for the standard visit.**

**FEES**_____ (initial)
Payment is due at the time of service. If you have not previously verified your mental health copayment, a payment of $100.00 will be required at time of service. You are responsible for the timely payment of all services rendered, even if health insurance may ultimately pay for a portion of your balance. Under special circumstances, your counselor may be willing to discuss other fee arrangements. A 10% charge will be applied to any unpaid portion on your account, accruing every thirty days.

**Standard Fee Schedule**

| | |
|---|---|
| Initial Intake Interview | $150.00 |
| Individual Psychotherapy (45-50 min.) | $130.00 |
| Family/Marital Psychotherapy (45-50 min.) | $130.00 |
| Reports/correspondence (e.g., Soc. Sec. Disability, FMLA) | $15.00 – $25.00 |
| Court testimony/Deposition Fee | $175.00 hour |

**If your account should become delinquent and collections are sought, you will be responsible to pay the collection cost.**

**INSURANCE COVERAGE** _____ (initial)
If you have health insurance, part of your expenses may be covered. Please call your insurance carrier by dialing the number on your insurance card to verify services covered. **We request a three day notice should your insurance change, in order to verify benefits and request proper authorization.**

I have read the Office Policies outlined above and consent to abiding by these guidelines.

_____ _____
Client's Signature Date

# Betty Kratzenberg, MS, LMFT

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you with your consent.

**Payment:** We may use and disclose your health information to obtain payment for services provided to you per your consent.

**Healthcare Operations:** We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staff's performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

**Your Authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while

it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We may disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

**Persons Involved in Care:** We may use or disclose health information to notify or assist in notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

**Required by Law:** We may use or disclose your health information when we are required to do so by law, such as in legal response to valid judicial, administrative subpoenas or court orders.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

**Appointment Reminders**: We may provide you with appointment reminders (such as voicemail messages, postcards, or letters) unless you make a specific request to the contrary. (See alternative communication section).

**PATIENT RIGHTS**

**Access:** You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We will use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first request for copies. We will charge $0.10 a page, $15.00 per hour for staff time and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information, you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied

your request. In some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.

**Disclosure Accounting:** You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include: disclosures made for treatment, payment or health care operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization; or disclosures made for law enforcement purposes. You may request one such record at no charge every twelve (12) months. The record request must state the time period desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to April 14, 2003. The first disclosure record request in a 12-month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any costs.

**Restriction:** You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will make reasonable efforts to accommodate your request.

**Amendment:** You have the right to request that we correct your records if you believe information in your record is incorrect or that important information is missing, by submitting a written request that provides your reason for requesting the amendment. We have the right to deny your request to amend a record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion that record is accurate.

**Questions and Complaints:**
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

**Privacy Officer:** Betty Kratzenberg, MS, LMFT
34 Erlanger Road
Erlanger, KY 41018
Facsimile #: 859-341-5783

# Betty Kratzenberg, MS, LMFT

ACKOWLEDGEMENT OF NOTICE OF PRIVACY

Effective 04/14/2003

**I acknowledge that I have received a copy of the Notice of Privacy Practices. The effective date of the notice is April 14, 2003.**

Client's Name:_____ Date:_____

Signature of Client or Authorized Guardian:_____

Relationship of Authorized Guardian to Client:_____

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (specify) _____

_____ _____

Signature of Professional Attempting to Obtain Signature Date

# Betty Kratzenberg, MS, LMFT

CLIENT SURVEY- BIRTH TO FIVE

Client's Name: _____ Date: _____

## IDENTIFY STRENGTHS

*Let's start by identifying your child's strengths. These are the building blocks from which change can take place, please do not leave these blank.*

- Attachment (trust/believes adults, acts happy when adult returns, etc.):_____
  _____
- Self-Control (shows patience, accepts another choice when first choice is unavailable, etc.):_____
  _____
- Initiative (does things for self, keep trying when unsuccessful, etc.):_____
  _____

## FAMILY INFORMATION

*Please identify all those people who currently live with your child.*

| Name | Age | Relation to Child |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*Other family members or persons important in your child's life that was not mentioned above, include all siblings:*

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child ever lived with anyone else or been in foster care? ☐ Yes ☐ No
If yes, please elaborate:_____
_____

Marital History of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married
If divorced or separated, what age was the child? _____months/ _____ years old
Please describe visiting/custody arrangements: _____
_____

Please list any person(s) who died that played an important role your child's life: _____
_____

Counselor Notes: _____
_____
_____
_____

## PRESENTING CONCERN

*Please check any of the following for which you are seeking help for your child:*

- ☐ Nightmares
- ☐ Sleeping Difficulty
- ☐ Fearfulness/Nervousness
- ☐ Social Withdraw
- ☐ Depression/Sadness
- ☐ See/Hear things not real
- ☐ Inappropriate sexual play
- ☐ Parental Stress
- ☐ Speech Problems
- ☐ Aggression toward adults
- ☐ Aggression toward peers
- ☐ Temper outbursts
- ☐ Irritability
- ☐ Not obeying rules
- ☐ Running away from you
- ☐ Constant Crying
- ☐ Threatens to hurt self or others
- ☐ Motor skills problems
- ☐ Significant weight gain/loss
- ☐ Does not get along with peers
- ☐ Problems concentrating
- ☐ Hyperactivity
- ☐ Destructive behavior
- ☐ Clingy behaviors
- ☐ Fire setting
- ☐ Bladder/bowel control issues
- ☐ Frequent Illness

Other: _____

Has your child ever experienced: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse
If yes, by whom: _____ though what age? _____

Has your child ever witnessed domestic violence? ☐ Yes ☐ No
If yes, between whom? _____ though what age? _____

How long have these behaviors been a concern? _____
Have you ever sought help for these concerns before? ☐ No ☐ Yes
If yes, from: _____
What has been done to address these concerns? _____
_____

What are your goals for treatment? _____
_____
_____

## SOCIAL INTERACTIONS

Does your child regularly interact with other children? ☐ Yes ☐ No
If yes, are the children: ☐ Same age ☐ Older ☐ Younger

Your child: ☐ makes friends easily ☐ has few friends ☐ has friends, but fights frequently
How well does your child get along with his/her siblings?
☐ Better than average ☐ Average ☐ Worse than average ☐ Not applicable- no siblings

How does your child react to strangers: ☐ No fear ☐ Hesitant ☐ Panics around new people
Child's favorite pastimes are: _____
Child participates in organized religion: ☐ Yes ☐ No If yes, please identify: _____
Counselor Notes: _____
_____
_____
_____

## FAMILY PERCEPTIONS

Strengths (what your child does well):

_____
_____
_____
_____

Needs/Concerns (areas where child struggles):

_____
_____
_____
_____

Please list five words that describe your child:

1) _____
2) _____
3) _____
4) _____
5) _____

## LEGAL HISTORY

Is there current involvement in the family by Social Services? ☐ Yes ☐ No

If yes, name of worker:_____

Reason for involvement:_____

Has there ever been involvement with the family and Social Services? ☐ Yes ☐ No

If yes, list reason and outcome: _____

_____

Other legal involvement outside of Social Services? _____

_____

_____

## OTHER INFORMATION

Other information you would like your counselor to know: _____

_____

_____

_____

_____

Completed by (signature): _____ Date: _____

Counselor Notes:_____

_____

_____

_____

_____ Date:_____

Signature of Clinician

# Betty Kratzenberg, MS, LMFT

CONSENT TO TREAT A MINOR

We, (Parents Names) _____ and _____ are legal custodial parents with decision-making responsibility for (Minor's Name) _____, a minor. (If sole legal custodian, please attach a copy of Permanent Court Order Provision.)

We authorize Betty Kratzenberg, MS, LMFT in her capacity as Licensed Marriage and Family Therapist to begin the mental health assessment and treatment of said minor on (Date) _____. Authorization will be in effect until such time as this psychotherapeutic relationship is terminated.

As legal custodial parents, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

Both parents must consent for treatment unless the treatment is court ordered (please provide order) or one parent is sole legal custodian (please attach provision).

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness/Provider Date