TARGETED CASE MANAGEMENT

FAQ & Sign-Up Sheet

WHAT IS CASE MANAGEMENT?

Case Management is a lot like social work without a license or related fees. Case Managers at KCC work in close contact with clients in order to improve financial, social, personal, and family situations and environments.

HOW CASE MANAGEMENT CAN HELP YOU

Case Managers work on a wide variety of issues, some of the most common include: Disability assistance, housing, transportation, SNAP benefits, education, employment, utilities, medication management, attorney referrals, school interventions for children, and much more - just ask!

WHAT HAPPENS NEXT?

Once you're signed-up for Case Management services, you will be contacted by your Case Manager within 48-hours. You will complete a short intake meeting, and then meet 2x per month. Most times your case manager will make sure to see you when you're already in the office for therapy or medication, but they also work in-home, in the community, and in schools.

Yes, I am interested in Case Management ☐

Client/Guardian Signature: Date:

Clinician Signature: Date:

You may fax forms to our office: 502-631-9660

Client Information:

Last Name First Name Middle Initial

_____

Home Address

_____

City State Zip

Phone number(s) Social Security Number

_____ _____

DOB Emergency Contact Name/Phone Number

_____ _____

FOR MEDICAID RECIPIENTS:

Name of Insurance Company _____

Member ID Number _____

Medicaid ID Number (Can be found on the card with the horse logo) _____

ONLY COMPLETE IF INSURED THROUGH PARENT OR EMPLOYER:

Name and DOB of Policy Holder_____

Relationship to Client_____

Place of Employment_____

Name of Insurance Company_____

Member ID_____ Group Number_____

Copay Amount_____ Annual Deductible Amount_____

Comments: _____

Primary Care Communication Form

Please complete this form if you would like our office to inform your doctor that you are being treated by Kentucky Counseling Center:

Today's Date: _____

Client Name: _____DOB: _____

Primary Care Office: _____

Phone number: _____Fax: _____

This letter is to inform my primary care doctor that I am receiving services at **Kentucky Counseling Center** for:

_____

Symptoms or Diagnosis

I plan to receive the following treatments while in the care of Kentucky Counseling Center:

____ Therapy

____ Medication to reduce mental health symptoms

____ Both

I give Kentucky Counseling Center and my PCP office, listed above, permission to share my private health information with each other. This consent does not expire until I submit written request to terminate communication.

Client Signature Date

Provider or Administrative Staff Signature Date

INFORMED CONSENT

By signing this form, you agree to receive mental health services provided by Kentucky Counseling Center, LLC, and its independent contractors. We know that starting counseling is a big decision and you may have many questions. We will do our best to answer any questions or concerns. This form explains information about KCC policy, State and Federal Laws, and your rights about counseling. All KCC employees and contractors have met the highest level of education, certification, and licensing requirements set forth by Kentucky state law. Counseling practices, philosophy and plan limitations and risks will be discussed with you today.

TREATMENT PROCESS AND DOCUMENTATION

It is the mental health professional's responsibility to keep accurate records including Evaluations, Treatment Plans, and Progress Notes. By signing this document, you are consenting to the Treatment Plan that your provider creates and agree to any goals, objectives, and therapy techniques that may be used in your therapy process.

INSURANCE BILLING

If you plan to use insurance to pay for services, claims will be sent to the insurance company based on information used at the time of service. Sometimes, insurance information may change or may not be up to date. If for any reason, inaccurate information related to deductibles, co-pays, or number of available sessions, etc. is retrieved at the time of service, KCC will bill the client for any additional costs associated with mental health services rendered. Additional services may not be provided until the client's balance is current. If balances remain unpaid for 60 days, client information will be sent to a collection agency.

MISSED APPOINTMENT FEES

Appointments will be cancelled and $25.00 fee will be assessed if client is 15 minutes late without notice. If client cancels appointment without a notice greater than 24 hours, KCC will charge the client $25.00.

RETURNED CHECK FEE

If your check is returned, your account will be assessed a $35.00 fee.

CREDIT CARD PAYMENTS

You may choose to have KCC store your credit card information for future bills you may incur. Should you do so, KCC will automatically process all outstanding balances one time per month and will not provide any additional warning other than what is written in this section of the Informed Consent form.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Confidential information discussed in session is not discussed with anyone without your written permission except for:

1. Diagnosis and dates of service shared with your insurance company to process your claims
2. Information you tell KCC about physical, sexual or elder abuse; then, by Kentucky State Law, I have to report this to the Kentucky Department of Children and Family Services
3. Where you sign a release of information to have specific information shared
4. If you tell KCC you are in danger of harming yourself or others
5. Information shared with therapist's clinical supervisor if applicable
6. When required by law.

If you need to contact me between counseling sessions please call my office. E-mail, text messages and social networking sites are not confidential and I may not be able to respond. If an emergency situation would happen, you can call my office to have a counselor call you. If no call is received within 15 minutes or you can't wait call 911.

Client Signature Today's Date

CLIENT RIGHTS (Client keeps this copy)

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

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.

Kentucky Counseling Center, LLC has been and will always be totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Your health information may be used for the purposes of providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Kentucky State Law, we are obligated to report this to the Department of Children and Family Services; If you provide information that informs us that you are in danger of harming yourself or others, we must report this also; Information may be used to remind you of /or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order;
Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

METHOD OF CONTACT BY OFFICE

We may send you appointment reminders by text message or phone call and leave a voice message.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I have read and received a copy of the Notice of Privacy Practices and Client Rights document.

_____

Signature (Parent/Guardian must sign if client is a minor) Date

Consent to Release Information

I consent for **Kentucky Counseling Center, LLC** and those representing this group to share my private health care information with the following individuals and/or entities. **KCC is permitted to send and receive information to and from the entities below if needed**:

1. Representatives of Child's School (School Name)-_____

2. Primary Care Physician Name-_____

3. Emergency Contact Name-_____

4. Other/ Self-_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to **Kentucky Counseling Center, LLC**. I understand that a revocation is not valid to the extent that **Kentucky Counseling Center, LLC** has acted in reliance on such authorization. This authorization does not expire until I submit a written request. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING PROVIDER OR ORGANIZATION: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for disclosure of this information by the recipient and, if that occurs, federal law may not protect the information.

_____

Client Signature (Parent/Guardian must sign if client is a minor) Date

_____

Clinician Signature Credentials Date

Patient Attestation Form/Participation in the Development of the Plan of Care

I _____ verify that I have participated in the development of the plan of care with my service provider, and that the plan of care is based upon my unique need and circumstances, as reported. I understand that an interdisciplinary team approach will be utilized for the achievement of this plan of care when warranted.

In signing this attestation I declare that my views and choices have been considered in the plan of care development.
For children: As parent/guardian of the child specified above, I give permission for collateral services on behalf of my child.
Date of initial plan of Care: _____

X _____ Date:_____
(Signature of client/parent/Guardian)

X _____ Date:_____
(Witness/KCC Staff member)