

# Breakthrough Counseling

Welcome to the Breakthrough group.

Thank you for placing your confidence in us. Our goal is for you to feel welcome each and every visit. Please let us know if you have any questions.

**Linda Russell, MHR, LPC**  
**Anna Johnson, MHR, LPC-S,**  
**Ashley Wyckoff, LPC, NBCC**  
**Monica Hamer, LCSW**

**2452 W New Orleans St**  
**Broken Arrow, OK 74011**  
**918-286-3278**  
**Breakthrough-Counseling.com**

Be sure to talk with your therapist if there are any questions about your treatment.

The front desk is ready to help you with any questions about your scheduled appointments or financial issues.

You will complete some necessary paperwork on your initial and 2<sup>nd</sup> visits. One of those forms includes a credit card guarantee. Once this form is completed with your number, it is scanned into an electronic HIPPA compliant platform and the paper with the number is shredded. Please carefully read the financial and missed appointment policies. This is a business and we respect the time and efforts of all the therapists. **A 24 hour cancellation notice is required if you are unable to make your scheduled appointment. If a 24 hour notice is not given, you will be assessed a \$100.00 charge for a late cancellation unless you are able to reschedule during the same week.** This policy insures that your therapist has the opportunity to be paid for their time. Our financial and missed appointment policies are in place to keep the best therapists available to serve you.

We want you to achieve your healthcare goals. As with all healthcare treatment, your best opportunity for positive outcomes of treatment is to keep your schedule of care and complete any homework assignments.

Again, thank you for choosing the Breakthrough group. We believe you are on the road to the breakthrough you seek and desire.



**Breakthrough Counseling, LLC**  
**Patient Information**

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_  
Address: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Student Status: \_\_\_\_\_  
Fax: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
SS Number: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**Custodial, Guardian Parent, or Other Billable Party Information**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Cell: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_  
Send bills to the name/address? Yes \_\_\_\_\_ No \_\_\_\_\_

**Primary Insurance Information**

Policy Holder Name: \_\_\_\_\_ Insured's ID: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Primary Insurance Co: \_\_\_\_\_  
Insured's date of Birth: \_\_\_\_\_ Employer Providing Plan: \_\_\_\_\_  
Patient Relationship to Insured: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Please notify the receptionist if you have secondary insurance coverage.**

This '**PHYSICIAN RELEASE**' permits your therapist to inform your Primary Care Physician (PCP) of your therapy.  
May we release your therapy information to your Primary Care Physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Please Notify: Dr. \_\_\_\_\_ Tel: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Release of Medical Information**

I authorize payment of insurance benefits to Breakthrough Counseling, LLC. I understand that I am financially responsible for any charges not covered by insurance or third-party payer.

I authorize the release of any medical information necessary to process this claim. Oklahoma State Law (O.S. 63 Sec. 1-5022) requires the following statement: The information may include records which may indicate the presence of a communicable or venerable disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immune Deficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS).

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## Breakthrough Counseling Informed Consent

**CONFIDENTIALITY:** Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law.

\_\_\_\_\_ **Initial**

**WHEN DISCLOSURE IS REQUIRED BY LAW:** Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that they present a danger to others. Disclosure may also be required by the courts. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

\_\_\_\_\_ **Initial**

**EMERGENCY:** If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

\_\_\_\_\_ **Initial**

**HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS:** Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier.

\_\_\_\_\_ **Initial**

**RECORDS AND YOUR RIGHT TO REVIEW THEM:** The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment.

\_\_\_\_\_ **Initial**

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please call us at (918) 286-3278. If we do not answer, we will return your call as soon as possible. If an emergency arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room.

\_\_\_\_\_ **Initial**

**THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE:** Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral,

cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe drugs.

\_\_\_\_\_ **Initial**

**TREATMENT PLANS:** On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits.

\_\_\_\_\_ **Initial**

**TERMINATION:** After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that a case, I will give you a number of referrals whom you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. And upon your request, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time.

\_\_\_\_\_ **Initial**

**DUAL RELATIONSHIPS:** Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are either unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

\_\_\_\_\_ **Initial**

**SOCIAL NETWORKING AND INTERNET SEARCHES:** At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

\_\_\_\_\_ **Initial**

I have read the above policies. I understand them and agree to comply with them:

**Client's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Therapist's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Patient History

Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

List symptoms you are experiencing, when they first started and how long they have lasted:

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Please provide your Mental Health History, previous treatment, with whom and for how long?

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Family Members with Mental Health Concerns: \_\_\_\_\_

Education, highest level achieved: \_\_\_\_\_

Current Job Status: \_\_\_\_\_ How long? \_\_\_\_\_

Medical history, current health: \_\_\_\_\_

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Medications, Dose: \_\_\_\_\_

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Herbals, Dose: \_\_\_\_\_

Allergies: \_\_\_\_\_

Alcohol Use (amount, frequency): \_\_\_\_\_

Cigarettes, cigar, other tobacco use (amount, frequency): \_\_\_\_\_

Recreational Drug Use (What, Amount, Frequency, Age of initial use): \_\_\_\_\_

Have you missed work due to drug use or drinking? \_\_\_\_\_ Have others expressed concern about your drug use or drinking? \_\_\_\_\_ Please List your Hobbies, Interests and Recreational activities: \_\_\_\_\_

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Spiritual Preferences:

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What do you hope to accomplish from your therapy?

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Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NO  
SYMPTOMS/STRESS

EXTREME  
SYMPTOMS/STRESS

\_\_\_\_\_  
Please place an "X" on the line above to indicate level of problem

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Breakthrough Counseling

## FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Welcome to Breakthrough Counseling. Please read over our financial and missed appointment policy. If you have questions, feel free to ask the Breakthrough Counseling staff.

### FINANCIAL POLICY

**Fees.** Counseling sessions are 45 minutes long. The fee for a 45-minute session, either face-to-face or by phone ranges from \$125-\$175 depending on your provider. We also ask you to place a credit card on file for future billing. A \$25 fee will be charged for any returned checks.

**Charges.** Occasionally there are extra charges or other altered charges but in your case the fee for the 45-minute sessions will be \_\$150.00.

**Insurance Patients.** If you have health insurance Breakthrough Counseling is happy to call your insurance company and verify your insurance benefits. We will also file your insurance for you. If your insurance covers a portion of your therapy, we will be happy to wait for 90 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

**Self-Pay Patients.** Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

**Methods of Payment.** Breakthrough Counseling accepts cash, checks, and major credit cards.

**Payment in Advance.** If your therapist suggests more than ten visits, you may pay for them in advance and receive a discount of .Payment for multiple visits must be made by the third visit.

### MISSED APPOINTMENT POLICY

Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged a \$100 fee unless you are able to reschedule during the same week. Appointments missed because of inclement weather will not be charged. Your fee will be applied to your credit card on file. All charges will appear as **Manhattan Management**. I understand it is my responsibility to maintain an **active and up to date credit card** on file to avoid any additional charges.

I have read and agree to the above conditions.

Name \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of Responsible Party)

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2446 W. New Orleans St  
Broken Arrow, OK 74011  
Phone: 918-286-3278  
Fax: 918-806-2647

## Consent to Treatment of Minor

I, \_\_\_\_\_ hereby give consent for  
(Name of Custodial Parent or Guardian of Child)

Breakthrough Counseling, L.L.C. and the staff and employees to treat  
\_\_\_\_\_ as a client/patient as of this  
(Name of Minor Child)

Date \_\_\_\_\_.

\_\_\_\_\_  
(Signature of parent or guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
(Witness Signature)

Date: \_\_\_\_\_





*Breakthrough Counseling*  
*2452 W New Orleans St- Broken Arrow, OK 74011*

**ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

**Notice to Patient:**

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.  
You may refuse to sign this acknowledgment if you wish.

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**I Acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

\_\_\_\_\_  
(Please Print your name here)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The Patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgment.
- We were not able to communicate with the patient.
- Other (Please provide specific details) \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**BREAKTHROUGH COUNSELING**  
**INFORMED CONSENT FOR VIRTUAL VISITS**

**Online Therapy:**

It is my expectation that you will benefit from online therapy as all or part of your psychotherapy, but there is no guarantee.

**Confidentiality:**

The information disclosed during your therapy is confidential. There are, however, legal exceptions including child abuse; elder and dependent adult abuse; threats to harm self or others; and court order. I will take all precautions to make sure that your video counseling is confidential. For one, your counseling will be provided through a HIPPA- compliant video conferencing platform.

*Please be aware, that despite security precautions, transmission of the online counseling sessions could possibly be disturbed or distorted by technical failures, or sessions could be interrupted or accessed by unauthorized persons. If you are concerned about this possibility, please discuss it with me so we can determine if online counseling is the best option for you.*

**When you should seek in-person mental health treatment:**

- If you are having thoughts of harming yourself (suicidal thoughts), harming someone else (violent thoughts towards others), or are feeling disconnected from reality (psychotic symptoms), please call **911** or **1-800-SUICIDE**, which is the National Suicide Hotline.
- If you are in an abusive or violent relationship
- If you have been seriously depressed
- If you have serious substance abuse dependence
- If you are a minor (under 18 years of age)

**What to do if there are technical difficulties or disruptions during video counseling:**

It is understood that when communicating by the internet or other electronic means, disruptions in service or other technical difficulties will likely occur from time to time. Should a disruption occur during a session you agree to immediately call me at **918-286-3278**.

By signing this form:

- 1) I agree that I reside in the state of Oklahoma.
- 2) I agree to call my therapist if there is an interruption in our video session.
- 3) I agree to participate in online psychotherapy. I have read, understood, and comply with the above policies.
- 4) I agree that the fee for my session is due prior to the session.

\_\_\_\_\_  
(Signature of Client)

\_\_\_\_\_  
Date