Kurt LaRose, MSW, LCSW

Mailing Address:
PO Box 180671
Tallahassee, FL 32318

Fla. Lic. #9297

Office Address:
220 John Knox Road, Suite 4A
Tallahassee, FL 32303

ONLINE USERS: By entering the words "I agree" I am stating that I have read and agree to all statements related to confidentiality, online security, privacy, and the use of public/private computers with saving, downloading and completing forms from the web, as read and reviewed at the URL: http://www.TalkifUwant.com/forms.htm: _____ (type or write the words "I agree")

AGREEMENT FOR COUNSELING SERVICES

APPOINTMENTS, CANCELLATIONS, FEE AGREEMENTS, COLLECTIONS, CONFIDENTIALITY, WAIVERS, THIRD PARTY PAYOR, AND COUNSELING TERMINATION TERMS

I, _____ (client first, middle, last name)
Born on _____ (Date of Birth)
Verified by _____ (License Number)

And residing at:

_____ (client address)
_____ (client city, state, zip)
(_____)_____ or (_____)_____ or (_____)_____ (client phone)
_____ (email address)

have read and reviewed the entire "Agreement for Counseling Services" document (ten [10] pages) and have discussed any and all questions or concerns I have, to my satisfaction, with the counselor/therapist, Kurt LaRose, MSW, LCSW. I understand that Kurt LaRose, MSW is a Licensed Clinical Social Worker (FLA. License# 9297) and is licensed to practice as a mental health professional in the State of Florida.

I reviewed this document on _____ (month, day, year).

As the named "client" I agree to participate in a treatment plan for counseling services, according to the terms set forth in the written treatment plan that is generated following the initial two or three assessment interviews (the first two or three sessions). I reserve the right to stop treatment at any time. I understand that in the event I refuse to participate in the treatment plan, LaRose will remind me of the treatment plan as it is outlined and according to the mandates of other parties – if applicable (see "COURT ORDER / MANDATED THERAPY, ASSESSMENT & CONFIDENTIALITY WAIVERS").

If I do not follow the treatment plan, and LaRose believes that failing to do so will in some way prevent me from meeting my treatment goals, he may terminate further counseling sessions with

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me. I acknowledge that if I am ever unable to reach LaRose in the case of an emergency, and feel very strongly that I need to speak to a counselor (for example if I believe that I may hurt myself or others), I may contact Telephone Counseling and Referral Services (24 hours per day) by dialing 211 (locally) or by calling 850-224-6333. I also understand that I can always go to the nearest emergency room.

CONFIDENTIALITY AND RECORDS ACCESSIBILITY

Confidentiality has been explained to me. I understand that my records will be kept confidential in the files that LaRose manages. Certain federal and state confidentiality laws protect mental health records; therefore accessing them is not permitted without written permission. Exceptions to confidentiality are provided under certain federal and state laws. In cases where safety is a concern, an exception to confidentiality exists, and it is legally mandated that confidentiality be broken to ensure safety.

Not all counseling records are available for access, even with written permission. I will have access to any and all Progress Notes, and I understand that I may have copies of them whenever I make a request to have copies provided to me. Therapy Notes are records that LaRose will have access to and I understand that these records will be kept confidential under nearly all circumstances as "privileged information."

All case notes, session notes, records, and content recorded related to specific hourly weekly sessions between LaRose and I, including all literal, actual, and paraphrased language shared between us in sessions, are considered Therapy Notes. Because Therapy Notes often contain not only information related to me, but also information related to other people of significance, I understand that releasing such information without other peoples' consent may be problematic.

Progress Notes are records that would normally be released to other professionals, and are usually generated at my request or the request of a third party. Progress Notes are the kind of notes that would be sent to someone else on my behalf, where Therapy Notes would not be, even if a signed release requesting Therapy Notes were provided to LaRose.

I understand that if I want copies of Therapy Notes I may have to get an attorney (at my own expense) and pursue a court order to get them and I understand that LaRose may take legal action to protect such records. LaRose may elect to release to me the specific type of records, namely "Therapy Notes," - at his sole discretion – even if I request copies of them. Progress Notes (and any requested records other than "Therapy Notes") that LaRose releases at my written request will be copied for me, and they will be delivered to me at a cost of $1.00 per page (plus postage if the records are mailed).

By signing below, I am stating that I fully understand that Progress Notes and Therapy Notes are two different kinds of records with different confidentiality standards – as noted above. In cases where the law may not provide for different confidentiality protections related to Therapy Notes and Progress Notes all legally executed judicial orders will be honored, only to the degree necessary to meet the minimum legal requirement.

By signing this form as the guardian of my child, if a minor is being seen for counseling, I understand that my child's counseling records will be kept confidential. I am aware that I may

have also signed a separate Parental Consent for Counseling Services permission slip, and if one has been signed at any other time prior or after this agreements signature date(s), the permission slip is incorporated into this counseling services agreement document by reference. As a legal guardian of your child, you acknowledge and understand that you have certain legal rights to medical records, which mental health counseling progress notes would generally be included as such.

I also understand that the rules of confidentiality change if I should express a desire to hurt myself or if I express a desire to hurt anyone else (including by knowingly and secretively spreading HIV). If LaRose believes that there is a danger to my life or to someone else's life, I understand that emergency contacts will occur to ensure safety. If I am the victim of abuse or if I am abusing anyone, I understand that this will be reported to authorities to ensure safety; Florida law mandates that mental health professionals report safety issues, and reporters who do so remain anonymous in all external inquiries, thus I will not be able to find out if LaRose makes a report, or if the report is made by someone else.

PRIVATE PRACTICE INFORMATION, CLINICAL SUPERVISION AND EXTERNAL REFERRALS

Kurt LaRose, MSW, LCSW has provided me with the website URL (www.TalkifUwant.com) related to his private practice and his professional, academic, and other experience related to clinical social work and mental health services. I also acknowledge that I have reviewed and signed this consent form expressing my desire to work with LaRose for the purposes of counseling. If I am the legal guardian of the named "client" I am providing my consent for counseling as the legal guardian by signing below.

I understand that LaRose is an independent private practice mental health professional, who also consults with another professional from time to time, namely with an experienced Registered Clinical Supervisor, Andrew A. Miller, LCSW. The supervisor may assist LaRose in effective treatment methods and may also provide consultation in the counseling services provided by LaRose, as appropriate and if/when needed. The Registered Clinical Supervisor, Miller, is bound by confidentiality laws as well, however identifying information related to my (your) case is not disclosed. In the event any professional consultation related to my (your) case were discussed with any other party, whereby I (you, the client) could in any way be identified as a client of LaRose, I (you) understand that LaRose will / must obtain written permission to disclose name and other identifying information.

If at any time, LaRose believes that he cannot provide my treatment, I understand that he may ask me to see an alternative mental health professional who may specialize in situations that are similar to mine.

I also understand that LaRose may request that I seek medical examination(s) by a medical doctor for the purposes of ruling out biological factors that may (or may not be) contributing to mental health issues. If I am referred to other professionals for services, at the recommendation of LaRose, I understand that I must make payment arrangements with them because they are not affiliated with LaRose's private practice.

FEE FOR SERVICES

I understand that the counseling services that I receive while working with LaRose are being provided for a fee. The fee for services has been negotiated between LaRose and I (or the third party payer) at a rate of $_____ per clinical hour (for each 50 – 55 minute session).

Payment for services is due at the time services are rendered (at the end of each session) unless the "Third Party" section of this agreement has been completed and signed by LaRose, you and the third party. Late payments and other payment delays are addressed herein, and will be settled according to the terms of this agreement and as outlined in the "OVERDUE, DEFAULT, COLLECTIONS AND ADDITIONAL COSTS" section of this agreement for counseling services.

Payment for counseling services is being made by:

__○__ Self OR __○__ Third Party Payer

If "Third Party Payer" is checked above, you (the client) must complete the THIRD PARTY TERMS section of this form (found elsewhere) and it must be verified as accurate and signed by the third party who is agreeing to pay for your counseling services. The acceptance of a "Third Party Payer" is indicated with your signature, the signature of LaRose, and the legally authorized agent of the Third Party Payer - before beginning counseling services. (NOTE: The above paragraph does not apply for State of Florida EAP cases – because payment arrangements are governed under separate terms between the EAP program and LaRose). In all third party payer arrangements, permission is granted to LaRose to release any and all information that is necessary to obtain payment (dates of service, Photo ID, Insurance Cards, date of birth, name, address, phone number, etc. etc.). Case notes will only be released with written permission.

OVERDUE, DEFAULT, COLLECTIONS AND ADDITIONAL COSTS FOR THE CLIENT AND/OR THE THIRD PARTY PAYER

The following collection terms are directed to the identified party checked under the sentence that says, "payment for counseling services is being made by:" in the "FEE FOR SERVICES" section (above) found in this document.

If I/WE, either as the client or as the Third Party Payer, pay Kurt LaRose, MSW, LCSW by check according to the fee for services agreement (where the financially responsible party is indicated) or by other payment methods, and my/our bank returns the check to LaRose, for any reason, I/WE agree to pay LaRose an overdraft fee of $55.00 or the current maximum allowable by Florida law (whichever amount is lower).

I/WE understand that the overdraft fee will be due even if I/we no longer use counseling services and I/WE understand that LaRose will exercise all legal means to collect the fee, including placing the check with a collection agency and/or filing for collection via the court system (criminal and/or civil).

If I /we fail to pay any amount due to LaRose for services rendered according to the payment terms herein, I/we fully understand that my/our name(s), address(es), telephone number(s), and amount(s)

past due will be placed with any agency or government body who has reasonable influence and power in rendering payment, including known credit reporting bureaus (local and/or national) for the purposes of collecting past due debt(s). In the case of credit reporting I/we hereby consent to the release of such information, and waive confidentiality protections, limited only to that information which is needed to report the past due debt; such information includes name(s), dates of service, fees for services, and billing address information, up to and including a complete copy of this "agreement for counseling services."

I/we understand that if LaRose initiates collections processes as listed herein, the released information will not include information regarding what is shared in counseling sessions and that all case notes, progress notes, therapy notes, assessments, and other records will remain fully confidential as protected by Federal and State laws. If my/our account is placed with a credit-reporting bureau, I/we understand that I/we will be responsible for an additional collection fee to cover the costs of initiating collections and credit reporting processes, as set by the collections bureau. The report to a credit bureau (and/or legal proceeding documents) will specify, if the credit bureau (or court authority) requires specificity, that the services rendered were "Contractual Professional Services provided by Kurt LaRose, MSW, LCSW."

Finally, any other legal costs that might be incurred by LaRose to collect any debt that may arise as the result of this agreement are costs that I/we fully assume and agree to pay - in addition to the cost for counseling services. "Other legal costs" include filing fees with the court system, bank fees, service fees, attorneys fees, as well as any other fees incurred that are considered a part of the recovery of "overdue" and/or "default" amounts. If such collections fees are incurred, these charges will be explicated in the invoices and fees as provided to LaRose, and passed onto the named "client" and/or third party payor.

"Overdue" and "default" is defined and indicated when/if the amount due on any invoice (or returned check) is 45 days past the statement date (or the actual date of the returned check). LaRose may or may not notify me/us prior to initiating collection processes thus I/we understand that if at anytime my/our account is in default or overdue, once such proceedings are initiated, I/we will incur all other fees as outlined herein.

In the event a financial matter remains unresolved due to collections issues, the additional fees, plus costs for services, are due upon receipt until such time as relief may be ordered by a court with jurisdiction to settle such disputes. If, in the course of such court proceedings, any part of this agreement is deemed null/void, such section(s) will be legally deemed as null/void, however all other sections of this agreement will remain valid and in tact, and contractually enforceable.

CANCELLATIONS, NO SHOWS AND LATE ARRIVALS

I, the named client, agree to call LaRose 24 hours prior to a scheduled appointment, if I need to cancel or re-schedule. "24 hours" is based upon business days of the week. For example, to cancel a Monday appointment "24 hour notice" means that the appointment would be cancelled by the previous business day - on Friday. In this example, if it is cancelled on Saturday or Sunday the "no show fee" would be assessed and due.

In the event of an emergency or some other extreme circumstance LaRose may (or may not), at his sole discretion, waive the no show fee. LaRose may/may not ask for validating documentation for "extreme circumstances" prior to any no show fee waiver. I (the named client or third party payor) agree that if a 24-hour notice is not given and if a no show fee is charged it is immediately due. The no show fee is equivalent to the agreed to negotiated fee for services. The client agrees that, because most third party payors will not make payment for "no show" fees, the named client – is responsible for payment upon receipt of the invoice that will be mailed to my (the client's) mailing address (as listed on page one of this document). The fee for no shows/non-cancellations is equal to the current published rate on the LaRose website (see "Prices & Fees" at www.TalkifUwant.com/prices_fees.htm).

Counseling sessions last for one clinical hour (50-55 minutes). They begin and end on time. I (the client) understand that if I arrive late to an appointment, and if LaRose is still able to see me (or my child), the session will end at the regularly scheduled time. I understand that full payment for the session is expected even if I am late to an appointment, and I agree to pay the full hourly rate.

BILLING CONSENT

I understand that if I am not making a full payment to LaRose during each of my sessions that LaRose (or his billing agent) will need to send invoices to other parties in order to collect payment for my sessions. I acknowledge that invoices may be faxed, mailed, emailed, and/or electronically submitted and that such invoices will include diagnosis codes (when diagnoses are made), session dates and times, as well as demographic information about me (such as my name, age, address). I grant LaRose (or his billing agent) permission to submit billing information as noted in this paragraph.

COURT ORDER & MANDATED THERAPY CONFIDENTIALITY WAIVER

The COURT ORDER & MANDATED THERAPY section

__◯__**IS APPLICABLE** or __◯__**IS NOT APPLICABLE**

If I, the named client, have been court ordered for mental health services or otherwise am legally mandated for counseling services, *or if I must obtain counseling services as a condition of my ongoing employment,* either for assessment or treatment - or both, I hereby authorize LaRose to communicate with the appropriate legal/governing/employment representative who monitors compliance. LaRose may communicate with the named person(s) below at will, via telephone, fax, email and/or standard mail, until such time as the mandate for counseling services is satisfied or withdrawn, according to the dictates of the appropriate governing authority. "At will," in the case of court ordered and mandated clients, means any information LaRose is asked to share by the authority who requires the client to attend counseling services, will be shared. The name of the person who oversees my counseling case is:

Contact Name: _____
Contact Title: _____
Agency Name: _____
Agency Address: _____
Agency City _____ , State: _____ Zip:_____
Agency Phone: (_____)_____ Fax: (_____)_____
Agency Email: _____

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I understand that such communication might impact the decision-making processes of the overseeing party who has mandated counseling services for me, and I release LaRose of any and all liability for communications that might have such an effect on me, even in cases where such communications may have a negative impact on me (legally or otherwise).

I am agreeing to counseling services because of the above mandate, thus I accept full responsibility for my own participation and any and all subsequent benefits (as a result of therapy methods) and/or consequences (as the result of non-compliance with mandated participation) accordingly, while acknowledging, again, that LaRose will communicate with those I have named above.

With my signature below I consent to this waiver of confidentiality due to mandated circumstances:

_____

Client Signature (confidentiality waiver) Date Signed

_____

Client Printed Name

_____

LaRose Signature (confidentiality waiver) Date Signed

CLIENT OVERALL AGREEMENT AND ACKNOWLEDGEMENT

I, the named client, have read the "Agreement for Counseling Services," including all of the applicable "Third Party Payer" sections of this agreement in the preceding and subsequent pages in its entirety, and I have asked questions and addressed any concerns I have, to my satisfaction. By signing this form, I understand that I am agreeing to all of the terms listed herein (preceding and subsequent sections), and freely sign in agreement to proceed with my treatment.

_____ _____

Client Signature Date Signed

_____ _____

Kurt LaRose, MSW, LCSW Signature Date Signed

_____ _____

Witness Signature (*if available)* Date Signed

_____ _____

Witness Printed Name(*if available)* Title

[Agreement continues for third party terms; clients must read, agree and sign the following sections if there is a third party making payment for sessions]

THIRD PARTY TERMS

(Client & counselor both must read and sign this section if third party terms apply)

The THIRD PARTY section

__○__**IS APPLICABLE** or __○__**IS NOT APPLICABLE**

We _____ *(this line is left blank for state EAP referrals,* otherwise enter the agency name of third party payer), agree to make payment for the counseling services according to all of the terms listed in this "Agreement For Counseling Services" document. The amount due for each clinical hour is listed in the "Fee for Services" section of this agreement and we agree to pay this fee for each session on behalf of the named client. We also agree to pay for each session that is set up between the named client and LaRose, until such time as we notify LaRose in writing that we no longer will cover the costs of counseling services.

We agree to provide written notification to LaRose of intent to stop payment, and to provide a non-payment notice at least 15 days prior to our intent to stop payment for counseling services. We agree to pay for all sessions that have occurred prior to LaRose's receipt of the written notice to discontinue payment and we further understand that discontinuance of payment simultaneously ends the confidentiality waiver that is contained in this agreement for counseling services. Regardless of payment responsibility, counseling sessions may or may not continue, according to the request of the named client.

As the third party payer, and/or as its legally authorized agent, I/we understand that payment is due upon receipt of each invoice, which will generally be submitted monthly. Payment is due according to all other terms of the "Agreement For Counseling Services" even in cases of cancellations, no shows, and late arrivals (see "CANCELLATIONS, NO SHOWS and LATE ARRIVALS" section for cancellation and no show terms). If we (the third party payor) refuse to make a "no show" payment for the named client, we acknowledge that LaRose will bill the client for the fees – up to and including the initiation of collection proceedings to do so.

As the third party payer, we understand that confidentiality standards will be honored and complied with according to federal and state law. If we are seeking access to certain records related to the named client, named and identified in the opening paragraph of this agreement, the named client has signed the appropriate confidentiality waiver (see "COURT ORDER / MANDATED THERAPY, ASSESSMENT & CONFIDENTIALITY WAIVERS" to verify records access as approved by the named client) and/or the release of information is limited to the information related to this client, as specified in the "Billing Consent" section of this agreement.

We (the third party payor) have also read and understand the difference between "Progress Notes" and "Therapy Notes" and are aware that we (the third party payer) may not have access to all of the documents in the files maintained by LaRose, even if we request them and even if the named client has granted permission to such records (for example, therapy notes will not generally be released even if the client requests them – however progress reports will always be

released when the client consents). Records access, in excess of necessary billing information, is only available when/if the named client provides written consent, and it is important for the third party payer to be aware that the client may withdraw any consent that they previously provide to LaRose - at any time.

We (the third party payor) agree to keep all communications from LaRose confidential related to the named client herein according to the laws that regulate employee records in the State of Florida, and according to all other personnel policy and procedure guidelines that exist in our agency. We (the third party payor) understand that if we obtain communications from LaRose, that the counseling records that LaRose forwards to us, must be kept in a locked and secured location at all times.

We further understand that even though a confidentiality waiver may have been granted for LaRose to communicate with us about the progress of the named client, that all mental health records, even as the third party payer, are protected under state and federal law. Under no circumstances can such records be discussed, communicated about, or shared in any way, shape, form or manner by any other parties (other than those named specifically and herein) without the written and expressed consent of the named client. Third Party Payor Billing Information:

Third Party Agency/Company Name:_____
Third Party Contact Name: _____ Title: _____
Third Party Address: _____
Third Party City: _____, State:_____ Zip:_____
Third Party Telephone: (_____) _____ Third Party Fax: (_____)_____
Third Party Email:_____

THIRD PARTY AGREEMENT WITH CLIENT & COUNSELOR CONSENT

I/WE as the third party payer for counseling services, the named client, and the counselor have read the "Agreement for Counseling Services" in its entirety (ten [10]), and have discussed and resolved any concerns to my/our satisfaction (see page 10 for list of concerns, if applicable). We (all parties in this agreement) understand that the terms of this agreement are binding between LaRose and each of us respectively, and in accordance with those sections that are specific to each of us individually as well, with our signatures below. By signing this agreement for counseling services, I/we understand that I/we are agreeing to all of the terms listed above and in this entire document, and we freely sign in agreement to proceed with the named terms listed herein and throughout this entire document:

_____ _____
Client Consent For Third Party Assistance (Client Signature) Date Signed

_____ _____
Third Party Authorized (Signature; blank for state EAP) Date Signed

_____ _____
Third Party Printed Name Date Signed

_____ _____
Kurt LaRose Consent For Third Party Assistance (Signature) Date Signed

Save & Print Reset Form LaRose Website

The following section will be completed by the counselor during the first session

The QUESTION, CONCERNS AND RELATED NOTES Section

__○__ **IS APPLICABLE** __○__ **IS NOT APPLICABLE**

QUESTIONS, CONCERNS AND RELATED NOTES ARE LISTED ON THIS PAGE DURING THE INITIAL APPOINTMENT – AND DATED UPON THE PLACEMENT OF FINAL SIGNATURES BY THE NAMED CLIENT AND LAROSE WHEN/IF QUESTIONS AND CONCERNS ARE DISCUSSED; IF QUESTIONS ARE LISTED HERE, BOTH PARTIES WILL INITIAL TO NOTE THE DISCUSSION AND THE DATE OF SATISFACTORY AGREEMENT TO PROCEED IN EACH AREA:

[THIS PAGE IS OTHERWISE LEFT INTENTIONALLY BLANK TO INDICATE THAT NO CONCERNS & QUESTIONS ARE/WERE DISCUSSED PRIOR TO THE BEGINNING OF COUNSELING, EFFECTIVE WITH THE DATES & PREVIOUSLY SIGNED PAGES]

_____ Initial LaRose _____ Date

_____ Initial Client _____ Date

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