Hello and welcome to Keweenaw Counseling Services. Congratulations on taking a positive step in your recovery journey from whatever problem brings you here.

I know entering therapy can be daunting, unsettling, and a bit uncomfortable to begin with so I hope this letter of introduction helps you feel more at ease and possibly even eager to get started!

A couple of things to know before your first session. First, and most importantly, is this is all about you! Everything matters; your thoughts, feelings, experiences, hopes and dreams. Our work together is meant to guide you towards whatever goals you set for yourself.

Second, everything you share is held is the strictest confidence. Laws of privileged communication govern therapeutic communications, but know also that I personally take this very seriously as therapy is only effective if you feel safe and trust the process.

Third, therapy is as successful as you make it. We can only work with what you choose to bring to each session. Honesty and a willingness to look deeply at thoughts, feelings, and behavioral patterns that no longer serve a good purpose is essential to finding solutions and a better way forward. While I will never judge you, I will challenge you to reassess what doesn't work, and find what does.

Finally I truly believe that every person has within them the wisdom and ability to achieve their goals, to thrive, and to find meaning in their lives.

I look forward to meeting you. Let's get started!

~Kyle Duquette

Kyle Duquette • MA, LMFT
902 Razorback Drive, Suite 5 • Houghton, Michigan 49931 • www.KeweenawCounselingServices.com • (906) 281-9999

KEWEENAW COUNSELING SERVICES PLLC
KYLE LYNN DUQUETTE MA, LMFT
MARRIAGE AND FAMILY THERAPIST
902 RAZORBACK DR. SUITE 5
HOUGHTON, MI 49931
(906) 281-9999
KYLE@KEWEENAWCOUNSELINGSERVICES.COM

Consent to Therapy

Client Rights and Responsibilities

Client Rights:

- You have the right to receive services without discrimination regarding race, religion, gender, ethnicity, age or handicap.
- You have the right to be treated with respect and granted confidentiality as defined be Michigan law and the American Association for Marriage and Family Therapy.
- You have the right to participate in the formation of an individualized treatment plan.
- You have the right to access and review your clinical records at any time.
- You have the right to refuse or terminate therapy at any time.

Client Responsibilities:

- You have the responsibility to participate in treatment by engaging in the therapeutic process, communicating your needs and tending to your own health and well-being.
- You have the responsibility to participate in the formation of your treatment plan and the execution of therapeutic change.
- You have the responsibility to provide 24-hour notice for cancelled appointments.
- You have the responsibility to provide payment for therapeutic services. Payment is accepted in the form of cash, personal checks, credit card, or pre-approved insurance. Lack of 24-hour notice of cancellation will result in a $80 fee which will be payable before your next appointment.

Legal Limitations to Confidentiality:

- If you present an imminent threat towards self or others.
- If you are involved in past or present abuse towards children or elders.
- If ordered by a court of law
- If agreed upon by entering into a signed *Release of Confidentiality.*

I have read and understand my *Client Rights and Responsibilities* and consent to receive therapeutic services by signing below.

Client Name (printed) Date

Client Signature (Parent/Guardian for minor client) Date

Witness Signature Date

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Client Information

Name:_____ DOB:_____ Age:_____

Home Address:_____

Mailing Address:_____

Phone# Home:_____ Work:_____ Cell:_____

Email:_____

Employer:_____ Position:_____

Emergency Contact:_____ Phone #_____Relationship:_____

Primary Health Insurance:_____ Subscriber #_____

Secondary Health Insurance:_____ Subscriber #_____

Medical Information

History of past illness:_____

_____

Current illness being treated:_____

_____

Any medications being taken currently:_____

_____

History of mental illness:_____

_____

Substance use/abuse history:_____

_____

Additional pertinent medical information:_____

_____

_____

_____

Family Information

Marital Status:_____ Children:_____ Age/Gender:_____

Age/Gender of Spouse/Partner:_____ Occupation/Employer:_____

Domestic violence/abuse in current family arrangement:_____

_____

History of domestic violence/abuse in family of origin:_____

_____

Substance use/abuse in current family arrangement:_____

_____

History of substance use/abuse in family of origin:_____

_____

Physical or mental illness in current family arrangement:_____

_____

History of physical or mental illness in family of origin:_____

_____

Any additional pertinent family information or concerns: _____

_____

_____

_____

_____

Therapy Experience/Needs

Past therapy experience:_____

Family members in therapy:_____

Reasons for seeking therapy:_____

Any additional pertinent information you feel would be helpful:_____

Michigan HIPAA Notice Form

Notice of Therapist's Policies and Practices to Protect the Privacy of Client Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND COMPLETE THE SIGNATURE FORM.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

As your therapist, we may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

* "PHI" refers to information in your health record that could identify you.
*"Treatment, Payment, and Health Care Operations"

Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist. *Payment* is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

* "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
*"Disclosure" applies to activities outside my office such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing.

You may not revoke authorization to the extent that

1) we have relied on that authorization; or
2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

*Child Abuse – If we have reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.

*Health Oversight Activities – If we receive a subpoena or other lawful request from the Department of Health or the Michigan Board of Psychology, we must disclose the relevant PHI pursuant to that subpoena or lawful request.

*Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or

where the evaluation is court ordered. You will be informed in advance if this is the case.

*Serious Threat to Health or Safety – If you communicate to me a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm to yourself, we may disclose information in order to protect you.

*Worker's Compensation – We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

Client's Rights and Therapist's Duties

Client's Rights:

*Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction you request.
*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. On your request, we will send your bill to another address.
*Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
*Right to Amend – You have the right request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
*Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
*Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

*I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
*We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
*If we revise our policies and procedures, we will provide you with a revised notice.

Complaints

If you are concerned that we have violated our privacy rights, or you disagree with a decision we made about access to your records, you may contact our office at (906) 281-9999.
You may also send a written complaint to the Secretary of the US Department of Health and Human Services. We can provide you with the appropriate address upon request.

Effective Date, Restrictions, and Changes to Privacy Policy

This notice goes into effect on January 1, 2011 in compliance with the Federal Health Information Portability & Accountability Act (HIPAA).
We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice.

My signature indicates that I have been offered a copy of the Michigan HIPAA Notice Form and I agree to the terms.

_____

Client or Parent Signature Date

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PRACTICE POLICIES

Fees: Private pay for an hour session is $120 and a 1.5 hour session is $175. Fees are due at the beginning of the session. KCS retains the right to adjust or raise fees as deemed necessary. Existing clients will not be assessed additional fees without 30 days written notice of fee change. We also accept Mastercard, Visa, American Express and Discover cards. Insurance is being updated at this time.

Missed Sessions: Unlike doctors in other medical specialties, we do not have other clients in a waiting room to fill your time when an appointment is missed. Accordingly, please leave a message with this office as soon as you know you are likely to miss an appointment. We often have a wait list of people who wish to have an earlier appointment. The sooner you can alert us to your need to cancel, the sooner we can give another person an opportunity to plan for that available appointment. For this reason, we request a 24 hour notice if you wish to cancel an appointment. If notice of cancellation is received less than 24 hours in advance, and we are unable to fill the appointment, there will be an $80.00 cancellation fee. Insurance companies do not pay for missed sessions, so the client is responsible for this cancellation fee. In the event of an emergency, cancellation fee may be waived at the discretion of KCS.

Copayment Fees: There is usually a copayment fee required. A copayment fee is the portion of the full fee which the insurance company expects you to pay. This amount is dependent upon your specific policy. The copayment fee is due and payable at the time of each session. This applies to insurance deductibles as well.

Treatment Availability: We know that your call is important and will get back to you as soon as possible. First sessions are generally scheduled within one week of initial contact. We make every effort to accommodate scheduling needs and with work and school conflicts. Sessions for children are prioritized during after school hours during the school year. Special accommodations can be made for evening or weekend sessions if necessary.

Request for Special Letters and/or Reports: Letters written on a client's behalf are usually charged by the time required for preparation. Insurance companies do not cover the cost of letter writing. Fees for report/letter writing are charged at $150 per hour.

I have read and understand all of the above policies.

Printed Name: _____ Date: _____

Signature: _____

Parent /Guardian Signature for Minor Client's:_____

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INSURANCE AUTHORIZATION FORM

CLIENT NAME: _____ BIRTHDATE:_____

I authorize my therapist, Kyle Duquette MA, LMFT/Keweenaw Counseling Services PLLC to release: The minimum necessary components of my personal health information for the purposes of billing and/or receiving permission to treat.

This form, when completed and signed, authorizes Kyle Duquette MA, LMFT/Keweenaw Counseling Services PLLC to release protected information from my clinical records to the entities/insurance companies listed below.
*Be sure to list both primary and secondary policies.

_____

_____

_____

_____

This authorization shall remain in effect until one year from the date entered below. I have the right to revoke this authorization in writing at any time by sending such written notification to the office address above. However, the revocation will not be effective to the extent that Kyle Duquette MA, LMFT/Keweenaw Counseling Services PLLC has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party. If this document is not signed, cash policies apply.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I, the undersigned, have insurance coverage with _____ and assign directly to Kyle Duquette MA, LMFT/Keweenaw Counseling Services PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Kyle Duquette MA, LMFT/Keweenaw Counseling Services PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Name of Client/Client's Legal Guardian (please print) Signature

_____ _____
Relationship to Client Date

(If the authorization is signed by a personal representative of the client, other than a parent, a description of such representative's authority to act for the client must be provided.)