lotz therapy

Today's Date: _____
Person completing forms: _____

Lotz Therapy REGISTRATION FORMS
(Completion does not guarantee services)

First Name | Middle Name | Last Name | Maiden/Former

_____
Preferred Name/Nickname

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth (MM/DD/YYYY) | Gender | Age

Street Address | City/State | Zip

Cell Phone Number | Work Phone Number

Occupation | Employer | Annual Household Income

_____
Your email address (Required)

_____
Do you prefer **email** or **text** appointment reminders?

Want occasional free tips on stress management & mental health from Lotz Therapy via email? (no spam ever) ☐ no ☐ yes

_____
Other Family Members Seen at Lotz Therapy

_____
Referred to Lotz Therapy By

If above client is a minor, please complete the following for the client's GUARDIAN:

Last Name | First Name | Relationship to Patient

Cell Phone Number (Required) | Work Phone Number | Home Phone Number

Street Address | City/State | Zip

Emergency Contact Information:

Last Name	First Name	Relationship to Patient
Cell Phone Number	Work Phone Number	Home Phone Number

Authorization to Treat

I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I agree to keep my, or my child's, scheduled appointments and understand that failure to do so may result in my care being terminated. By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it.

_____ _____

Client/Guardian Signature Date (MM/DD/YYYY)

Authorization to Treat Minor Child (if applicable)

_____ _____

Name of Child Date of Birth (MM/DD/YYYY)

I warrant that I am a custodial guardian of the above named minor child. I hereby give permission for him/her to receive therapy from Jeremy Lotz, MA, LPC, NCC. I acknowledge that I am aware of the mandated reporting laws in the state of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other guardian(s) that therapy has been initiated and will take sole responsibility in arranging for the payment for all therapy services for my child.

_____ _____

Client/Guardian Signature Date

INFORMED CONSENT

The decision to begin therapy may impact significant areas of your life. When you enter therapy with a good understanding of what you are about to undertake, you are likely to achieve more favorable results. This form contains information to help you make informed decisions about the process of therapy, my services, and policies.

Therapist qualifications and credentials - Jeremy C Lotz, MA, LPC, NCC is a Licensed Professional Counselor in the state of MIssouri, a National Board Certified Counselor, and an EMDR therapist.

Goals of the therapeutic relationship - Jeremy works with the goals established by his clients. He may add therapist goals for therapy, which he would be glad to share upon request.

Services the therapist can provide - Jeremy provides therapy from a systemic frame of reference and works with adults, teens, children, couples and families on a wide range of issues. Jeremy speaks on various therapy topics. Jeremy will suggest an approach tailored to meet your goals and obtain your approval before proceeding. Jeremy will also inform you of any additional fees for assessment instruments used in assessing therapeutic needs and goals.

Contacting me - Due to my work schedule, I often am not immediately available by telephone. When I am unavailable, my telephone is answered by my office staff or by my voicemail, which I monitor frequently. I will make every effort to return your call within one business day. If you are difficult to reach, please inform me of some times when you will be available. My telephone number does not honor text messaging. I am not available to clients via social media platforms (including but not limited to Facebook, Facebook Messenger, Instagram, LinkedIn); I will not be able to accept any friend / follow requests nor respond to messages sent via these platforms. In the event of an emergency, you need to call 911 or go to the nearest hospital emergency room. If you or your family member is experiencing suicidal thoughts or feelings, you should call the suicide hotline at 1-800-784-2433 or utilize one of the support numbers below. If I will be unavailable for an extended time, I will provide you with alternative contact information, if necessary.

Suicide 1-800-273-8255 or text HELLO to 741741
Domestic Violence 1-800-799-7233 or text SUPPORT to 741741
Self Harm 1-800-366-8288 or text CONNECT to 741741
Bullying 1-800-420-1479 or text HOME to 741741
LGBTQ+ 1-866-488-7386 or text START to 678678
Sexual Assault 1-800-656-4673 or text HOME to 741741
Grief 1-800-445-4808 or text CARE to 839863
Mental Health 1-800-950-6264 or text NAMI to 741741

Rights of the client - Jeremy is responsible for ensuring that his behavior adheres to the standards identified in the National Board for Certified Counselors (NBCC) Code of Ethics. You have a right to request a copy . You have a right to discuss your treatment approach and refuse any treatment. You have a right to ask for an estimate of the probable length of therapy. You have a right to request a referral to another therapist.

Behavior desired by the client - Jeremy often makes recommendations of things to do between sessions. Completing these should facilitate therapy and reduce the number of sessions needed. Please bring up any concerns that you have about therapy or your therapist so they can be resolved. Please be as open as possible concerning any issues that relate to your problems. Withholding information may cause therapy to take longer. Guardians of minor children need to be involved in the therapy in order for Jeremy to be effective. Please give 24 hours notice of needing to reschedule; 24

hours is required to avoid a fee, 72+ hours is preferred. You may be asked to update intake documentation if in therapy services for longer than one year.

Risks and benefits of therapeutic procedures - A benefit is that therapy may help you personally and with your relationships. A risk of therapy is that it may not by itself resolve your problem. Jeremy will assess your progress with you periodically to ensure movement toward your goals. An additional risk of therapy is that you may feel emotional or physical discomfort when processing uncomfortable topics (including EMDR if appropriate). Jeremy will always strive to monitor any discomfort and to prevent any unnecessary discomfort while you are striving to accomplish your therapy goals.

Financial considerations and arrangements - The session fees: Initial intake meeting is $200 per 90 minutes, follow-up visits are $135 per 60-minute session, and $160 per 90-minute EMDR session. You may pay via cash, check, charge, or Electronic Bank Transfer (if eligible). A valid credit card will be kept on file throughout therapy services.

Limits to confidentiality - All participating family members who are 18 or older will need to sign a written release. All information in therapy is confidential with some exceptions. Exceptions to confidentiality according to the laws of Missouri state regulations are:

1. If you reveal the intent to harm yourself and/or others
2. If there are reasons to suspect child or elderly abuse
3. In legal cases, the court orders the therapist to provide your records

My signature indicates that I understand and agree with the therapist's policies and give informed consent to receive therapy services from Jeremy Lotz, MA, LPC, NCC. To be signed by all participating family members 18 years old and over.

I acknowledge that I have received a copy of the therapist's Notice of Privacy Practices (HIPAA).

Client Signature (over 18 years) Date

Guardian Signature (to consent for clients under 18) Date

TREATMENT & HEALTH HISTORY

Medications currently taken and their purpose, & dosage (include non-prescription meds, sleeping pills, diet pills, etc

_____

Briefly describe why you're seeking counseling?

_____

Current Stressors (describe how the following areas are stressed)

Marriage & home _____

Children/parents _____

Work/School _____

Physical/Medical _____

Financial _____

Social _____

Spiritual _____

Sexual _____

What is the BIGGEST stress in your life? _____

How strong (scale 1 -10) is your desire is to change this stressor (1 = no desire; 10 = strongest desire) _____

How able do you feel (scale 1 -10) to have a good time 1 = no ability; 10 = highly able) _____

Previous counseling? ☐ no ☐ yes If yes, who & when? _____

What would you like to change about your previous counseling? _____

Have you had suicidal thoughts recently? ☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you had them in the past? ☐ frequently ☐ sometimes ☐ rarely ☐ never

Hospitalizations (reason/dates/diagnosis) _____

Do you consider yourself to be religious? ☐ no ☐ yes If yes, what is your faith? _____

Would you like religion/faith/to be integrated into your therapy? ☐ no ☐ yes (**PLEASE TURN PAGE**)

If yes, what would be helpful? _____

What are your strengths? _____

What are your children's strengths? _____

Are you having any problems with your sleep habits? ☐yes ☐no If yes, check all that apply:

☐Sleeping too little ☐Sleeping too much ☐Poor quality sleep ☐Disturbing dreams

What time do you have your last caffeinated beverage for the day? _____ AM / PM

What things do you do to help you fall asleep? _____

Using an "A," "B," "C," "D," "F" grading scale, please grade how you're currently doing in the following health areas. You may use + and minuses in your grades.

My Report Card

1. Daily hydration _____
2. Physical Fitness _____
3. Social Fulfillment _____
4. Amount of Sleep _____
5. Quality of Sleep _____
6. Screen time (phone, iPads, computers, TV) _____
7. Caffeine use _____

How many hours of screen time would you estimate you experience per day? _____ hrs

How many times per week do you exercise? _____ Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ☐no ☐yes

If yes, check where applicable: ☐Eating less ☐Eating more ☐Binging ☐Restricting

Have you experienced significant weight change in the last 3 months? ☐no ☐yes

How many alcoholic drinks do you have per week? _____ How often do you use marijuana? _____

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

Has anybody in your life expressed concern about your drinking? ☐no ☐yes If yes, who? _____

How often do you smoke cigarettes or use other tobacco products? ☐daily ☐ weekly ☐monthly ☐ never

Are you currently in a romantic relationship? ☐no ☐yes

On a scale of 1-10 (10 being highest quality), how satisfied are you in your current relationship? _____

CLIENT RIGHTS

YOU HAVE THE RIGHT:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purpose, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to affect the ongoing therapeutic relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the ongoing treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action.

CONFIDENTIALITY OF INFORMATION:

Laws ensuring your right to privacy protects matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse or neglect is known or suspected (reporting is required by law).
2. When the abuse of an elderly or dependent person is known or suspected (required by law).
3. If you commit a crime against a staff member or another person on the premises.
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.

SECURITY OF RECORDS:

Your treatment of record and related financial records are kept in a locked file cabinet. Records will not be made available to others without signed authorization to release information and payment for the records prior to releasing them. Special rules relating to the release of treatment records containing information regarding drug and alcohol abuse: CFT 42, PART 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. This information cannot be disclosed to another source without written consent. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is strictly prohibited.

RETENTION OF RECORDS:

Treatment records are retained for a period of seven years following the termination of treatment. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

INFORMATION REGARDING PSYCHOTHERAPY

1. Psychotherapy (CBT, EMDR, SFT, and all other clinical modalities) may involve remembering unpleasant events and can arouse intense physical and psychological discomfort, including but not limited to: feelings of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Feelings of relief, energy, power, self-acceptance, and well-being may also occur.
2. Psychotherapy is not always effective and may, in some cases, result in deterioration rather than improvement of clients psychological functioning. Psychotherapy has been shown effective in about 75% of cases.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. I will attempt to provide treatment that is realistic in both areas.

4. Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; I will make these recommendations if they are appropriate, based upon our assessment.

_____ _____

Signature of Client or Legal Representative Date

Cancellation and Fee Policies

Cancellation

- A 24-hour notice via email is required for all cancellations. 72+ hours is preferred.
- A session fee will be charged for missed sessions if 24-hours notice via phone or email is not provided.
- 2 No-shows will result in unsuccessful discharge from services.
- Session will be canceled and the session fee assessed if the client arrives more than 20 minutes late.

Email or text reminders may or may not be available as a courtesy based on technological availability. Courtesy reminders are not to be relied upon for remembering your scheduled appointment as errors can occur within this delivery process. I understand I am solely responsible for remembering my scheduled appointments.

Service	Fees
90-minute initial intake meeting - due at time of session	$200
60-minute therapy session - due at time of session	$135
90-minute EMDR session - due at time of session	$160
After hours phone calls or crisis calls	$160/hr
Composing letters or reports to parents, schools, employers, physicians, lawyers, etc	$135/hr
Court Testimony/Depositions	$450.00 flat rate plus mileage-This is a 3-hour minimum which is non-refundable and must be paid 72 business hours in advance. Each additional hour is $160.00 per hour.

I agree to the terms and fees above and will place a credit card on file for possible expenses.

_____ _____

Client/Guardian Signature **Date**

CREDIT CARD PRE-AUTHORIZATION

I authorize Jeremy Lotz at Lotz Therapy to keep my signature on file and to charge my account for payment of my fees in the amount established by Lotz Therapy as indicated below:

Service	Fees
90-minute initial intake meeting - due at time of session	$200
60-minute therapy session - due at time of session	$135
90-minute EMDR session - due at time of session	$160
After hours phone calls or crisis calls	$160/hr
Composing letters or reports to parents, schools, employers, physicians, lawyers, etc	$135 /hr
Court Testimony/Depositions	$450.00 flat rate plus mileage-This is a 3-hour minimum which is non-refundable and must be paid 72 business hours in advance. Each additional hour is $160.00.

24-hours notice via email is required for all cancellations. 48 hours is preferred. A session fee will be charged for missed sessions if 24-hours notice is not provided. Session will be canceled and session fee assessed if client arrives more than 20 minutes late to a scheduled appointment. Email or text reminders may be available as a courtesy. I understand courtesy reminders are not to be relied upon for remembering my scheduled appointment. Choosing not to 'confirm' an appointment via the courtesy reminder, does not constitute canceling an appointment. I understand I am solely responsible for remembering my scheduled appointments.

I understand that my information will be saved to file for future transactions on my account and that my card will be charged in the event that I fail to provide payment in full at the time of my session. I understand my card will be charged if I miss a session without proper notice or if payment is needed for after hours/crisis calls, FMLA/Letters, and Court Testimony/Depositions.

I understand that if I want to use my credit card for my session (s) that I will make a payment at the end of the session by using the physical credit card. I agree to the above terms and fees and agree that this authorization will remain in effect until canceled.

Client's Name: _____

Card Holder's Name: _____

Card Holder's Address: _____

City: _____ State:_____ Zip: _____

Email (the one your online statements come to): _____

☐ Visa ☐ Master Card ☐ American Express Acct. # _____

CSC#_____ (3-digit # on back of card) Exp. Date (month/year): ____/ ____ Phone: _____

Signature:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

A. Make sure that protected health information ("PHI") that identifies you is kept private.
B. Give you this notice of my legal duties and privacy practices with respect to health information.
C. Follow the terms of the notice that is currently in effect.
D. I can change the terms of this notice, and such changes will apply to all the information I have about you. The new notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

1. For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.
2. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
3. Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a healthcare item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable cost based fee for doing so.
5. The Right to get a list of the disclosures I have made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on June 1, 2016.

Acknowledgement of Receipt of Privacy Notice: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. **You acknowledge you have received and read this Notice.**

_____ _____

Client/Guardian Signature **Date**