Kami Moore (Brannon), LPPC
597 High St #1293
Worthington, OH 43085
(614) 886-4080
Kami.Kunz.LPCC@gmail.com
www.columbusqueertherapist.com

Today's Date: _____

********** Demographic Information **********

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Gender Identity: _____

Address: _____

City, State, Zip: _____

Email: _____

Cell Phone: _____

Where can I contact you: _____

Emergency Contact: _____

********** Insurance Information **********

Primaries Legal Name: _____

{ } Address same as above

Address: _____

City, State, Zip: _____

Relationship to Insured: _____

Primaries Date of Birth: _____ Primaries Gender Identity: _____

Primary Insurance Company: _____

Member ID: _____ Group ID: _____

Secondary Insurance Company: _____

Member ID: _____ Group ID: _____

********** **Credit Card on File** **********

Person Responsible for this Account: _____

{ } Address same as above

Address: _____

City, State, Zip: _____

Credit Card receipts sent to: **TEXT** or **EMAIL** Alternate destination: _____

Type of Card: _____ Expiration Date: _____

3 Digit Code: _____ Card Number: _____

My self pay rate is $65 a session which is typically less than most private insurance's contracted rate. Additionally, your balance after insurance will be assessed to your card on file. PLEASE COMMUNICATE CANCELATIONS/RESCHEDULED APPOINTMENTS AT LEAST 24 HOURS IN ADVANCE OR YOU WILL BE CHARGED A MISSED SESSION FEE OF $50. Without advance notice I am unable to fill your appointment time with another appointment. My livelihood is dependent on the income earned in private practice so I am very firm and consistent in upholding this policy. I do permit cancelations for legitimate emergencies. Legitimate emergencies do not include unexpected situations that are not emergencies, sleeping, working late, traffic and forgetting ect.. I appreciate your adherence and honesty in advance. Thank you!

I, _____, authorize Kami Moore, LPCC to bill this credit card for the amount listed above. I agree and understand the terms and will comply accordingly.

********** Informed Consent **********

I, the undersigned, do voluntarily consent and authorize outpatient treatment as judged to be necessary by my clinician. Such treatment may include diagnosis/assessment procedures, and psychotherapy. I understand that this consent authorizes the use of standard and customary community standards, and I have been advised of the potential risks and benefits associated with treatment. I understand the practice of mental health is not an exact science and I acknowledge that no guarantees have been made to me concerning my care. Because psychotherapy is a cooperative effort between patient and therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. If I refuse the treatment that is suggested for me or discontinue treatment, I will not hold Kami Moore-Brannon LPCC, dba Therapeutic Interventions LLC responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws require that my therapist report all cases in which there exists a specific potential harm to others or in cases of reported or suspected physical, sexual and/or neglect of children which are required by Ohio law.

********** Authorize for Disclosure of Information **********

The undersigned hereby authorizes Kami Moore-Brannon LPCC, dba Therapeutic Interventions LLC, to release or disclose information in the medical, business or clinical record of the patient of the following:

- Any private or public entity with which a claim is being filed for a (all or part) of the patient's charges, including any insurance carrier or compensation carrier or any of the respective agents, representatives, and claims processing personnel;
- Any attorney, collection agency or other persons or entities engaged in the collection of responsible party to Kami Moore-Brannon LPCC (dba Therapeutic Interventions LLC)
- Any other healthcare professional staff providing needed care;
- Any person, corporation, public or private agency to the extent necessary for Kami Moore-Brannon LPCC (dba Therapeutic Interventions LLC) to obtain and/or maintain licensure, federal and/or state reimbursement for the provisions of health care services or clarification;
- Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review;

- Any Kami Moore-Brannon LPCC (dba Therapeutic Interventions LLC) employee or provider requiring information including patient identity and address in order to provide care and/or maintain the medical records;
- For any release beyond the scope of this consent, the patient will be asked to sign a Release of Information Form.

The information release may include diagnosis and treatment including, but not limited to mental and physical condition, drug/alcohol and other information requested to determine coverage, medical necessity and other benefits determination.

This authorization may be revoked at any time except to the extent those actions have already been taken. To cancel this authorization, the patient and/or responsible party realizes that they must do so in writing and send it to Kami Moore-Brannon LPCC (dba Therapeutic Interventions LLC)

_____ _____

Signature of Patient **Date**

_____ _____

Spouse/Parent/Guardian **Date**

********** Policies & Procedures **********

Self-Pay Fees & Balances: All are due in full at time of your appointment. Initial sessions are billed at $125 for the initial session and $100 for every session that follows. Self pay clients rates are discounted to $65 per session. One parent must take financial responsibility for their child's account. Please handle whatever agreements are in place with your custodial agreements. Payments can be made via square, venmo, or the client portal.

Form Completion/WPATH letters: Requested form completions (Letters, FMLA, etc.), will be charged based on clinician time involved with a minimum $150 paperwork fee assessed. WPATH assessments/letters are $250. Please allow 7-10 business days. All forms are due prior to initial appointment. Both parents are required to sign off on minor children's counseling per Ohio law.

Record Transfers: There is a $25.00 fee to transfer patient records to other providers, due from the patient before the records will be sent.

Prior Authorizations: Patients are responsible for contacting their insurance companies.

After Hour/Emergency Fees: Appointments required after normal office hours (Mon–Thurs after 6:30 pm) will be assessed an emergency fee of an additional $100.00 only scheduled with clinician approval.

Phone consultations: A fee for extended telephone conversations beyond 10 minutes will be assessed at the clinician hourly rate of $100.00 per hour.

On Call Clinician: Clinicians are available for urgent problems only from 6:00 PM- 9:00 PM weekdays and 10:00 AM-1:00 PM weekends and holidays. For non-emergency questions, please contact our office the next business day. Please text me directly with the word "URGENT" as the first word in the text to schedule an after hours, crisis appointment.

**** If you are experiencing acute distress, self-harm or suicidal thoughts, please call 911 or go to your nearest emergency room or contact Netcare Access at: (614) 276-2273 (CARE) ****

Print name:_____ Signature:_____

Witness: _____ Date: _____

Policies and procedures are subject to change

_____Patient received copy of policy/procedures (please initial)

************ Appointments/Cancellations ************

- A 24-*hour notice* must be given when cancelling your appointment in order to avoid a charge. This will allow us to reach someone on our waiting list and offer them the appointment time.
- Failure to give 24-hour notice for cancellations will result in a charge of $50 which must be paid in full prior to scheduling another appointment.
- Late Arrivals may lose appointment times and will either need to reschedule.
- Termination of Service: Multiple late cancellations, no-shows and other forms of non-compliance with treatment may result in termination of services.
- Reminder texts: As a courtesy, we offer reminder texts about your upcoming appointment, typically 1 day in advance.

************ Professional Services ************

The fee for phone conferences, extended sessions, preparation of WPATH letters and treatment summaries, reading and responding to correspondence (including past records and email), site visits, travel time, and consultation with other professionals is $250.00 per hour. Payment is due at the time services are rendered.

Forensic Services: Fees apply to time spent and attorney's fees in connection with a subpoena or other record requests that your doctor might receive involving your (or your child's) treatment. This includes the cost of seeking to block a release of information to the court, should you choose this course. Fees will also apply to legal testimony, preparation time, travel time, and time spent waiting to testify. The fee for these services is $400.00 per hour.

Print name: _____ Signature:_____

Witness: _____ Date: _____

Policies and procedures are subject to change

_____Patient received copy of policy/procedures (please initial)

********** Scheduling **********

PLEASE CREATE AN ACCOUNT ON THE PORTAL VIA YOUR JITUZU EMAIL. YOU WILL BE ABLE TO SELF SCHEDULE, ACCESS VIDEOCONFERENCING, SEND ME HIPPA COMPLIANT MESSAGES, AND MAKE PAYMENTS VIA YOUR PORTAL ACCOUNT. PLEASE MESSAGE ME VIA THE PORTAL, TEXT AT (614) 886-4080 OR EMAIL ME AT KAMI.KUNZ.LPCC@GMAIL.COM WITH ANY QUESTIONS. LOOK FORWARD TO MEETING YOU!