Marci Ramsay, LSCSW, RPT-S
2500 W 6th Street, Suite F
Lawrence, KS 66049
785-330-5688

Professional Disclosure Statement for Clinical or Play Therapy Services

Welcome to my practice. Your first visit to a new therapist is very important, and you may have many questions. This document explains my qualifications to provide clinical services and play therapy, my view of therapy, and how I conduct therapeutic services. I will introduce myself and give you information to help you decide whether we can work together. Please take time to read it carefully and let me know if you have any questions or need more information. When you sign this document, it will represent an agreement between us.

Professional Credentials and Experience

My advanced degree is a Master of Social Work degree earned in 2006 from The University Of Kansas. I hold licensure in the state of Kansas as a Licensed Specialist Clinical Social Worker (#4179). In addition, I am a Registered Play Therapist/Supervisor (#S1960). I am Level 2 EMDR trained and I am currently pursuing certification in the Neurosequential Model of Therapeutics through the Child Trauma Academy.

I have been employed at Positive Bright Start as an Early Childhood Mental Health Clinician and Positive Behavior Support Administrator since 2007 and I've just recently opened my private practice in 2016. My primary practice is the assessment and treatment of children, birth through age 13. I offer clinical assessment and screenings for children, individual, client-centered services for children, family support, behavior consultation, and parenting education and training. I specialize in treating children with trauma-related conditions, including child maltreatment, posttraumatic stress disorder, and attachment or adjustment disorders which can arise as a result of removal from parents, divorce, moves and transitions, or the loss of a loved one. In addition to working with children and their caregivers, I provide training and consultation services to early learning centers and early learning professionals caring for children.

I utilize a variety of methods in the therapy process; choosing techniques based on the assessment results of each client, the presenting issues, and the client's cultural background. With young children, I use a variety of developmentally-based, play therapies to assist children with self-expression and problem resolution including child-centered play therapy, directive play therapy, ®Theraplay, and EMDR. Additionally, my work with children involves parenting education and support when there are stressors within the family system.

About Play Therapy

A common misconception is that play therapy is simply providing a child toys to play with while a therapist and child talk. To some extent this is true in certain circumstances related to age of child and phase of therapy the child is in. The remainder of this letter however, describes Child Centered Play Therapy and the role of play in the healthy development of a child.

Child Centered Play Therapy provides the child with a very specialized play therapy environment and therapeutic relationship that is different than any other place or person your child has experienced. The child completely leads their play and the therapist's understanding of the play behavior allows the therapist to enter more fully into the child's inner world. Your

child may be demonstrating a combination of social, emotional, behavioral, cognitive, language and physiological signs and symptoms that have caused his/her caregiver to be concerned and seek therapy. During play therapy, your child will simultaneously work on their problems and symptoms and will work to achieve any number of the following goals:

- Confronting their problems and symptoms
- Resolving conflicts
- Learning to problem solve using inner and outer resources
- Gaining self-control and self-direction
- Building self-esteem
- Developing coping skills
- Experiencing and tolerating painful emotions
- Regulating their emotions and discovering ways to cope with and express feelings
- Restoring developmental tasks to appropriate age levels

Play therapy is held in a special play room containing a wide range of carefully selected toys. The toys that are selected have no prescribed function but rather help elicit creativity, symbolism, emotions, problem solving, and real life situations. During play sessions, the child leads their own play and the therapist's responses communicate sensitivity, understanding, safety, acceptance, and belief in the child's capacity, rather than coming from a place of evaluation, shock, distrust, and disapproval. These responses and the relationship that develops allow children to discover and develop their inner resources and, in the process, experience the power of their potential. This is a gradual process that is to be respected and given patience, time, consistency on the part of the parents/caregivers and schools. Therefore, it is critical for the well-being of the child to not pull them out of therapy before they are ready. I will help you understand when a child is ready or why they are not.

I am here to support and educate you along the way to help you understand and provide continuing support to your child.

The Process of Therapy/Evaluation

During our first meetings, I will assess whether I can be of benefit to you. I do not accept clients who I believe I cannot be helpful to, and if this is the case, I will refer you to others who work well with your particular needs. Within a reasonable period of time after starting treatment, we will discuss my working understanding of your issues, work together to develop a treatment plan, and therapeutic objectives and possible outcomes of the therapy. If you have questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan in general, please ask me. You also have the right to ask about other possible treatments for your particular needs and their risks and benefits. If you could benefit from any treatments that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

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Office Policies & Agreement for Therapy Services

Termination and Follow-Up

Deciding when to stop our work together is meant to be a mutual process. Before we stop, we will discuss how you will know if or when to come back or whether a regularly scheduled "check-in" might work best for you. If it is not possible for you to phase out of therapy, I recommend that we have closure on the therapy process with at least two termination sessions.

You have the right to terminate treatment at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

If you commit violence to, verbally or physically threaten or harass me, the office, or my family, I reserve the right to terminate your treatment unilaterally and immediately. Failure or refusal to pay for services after a reasonable time is another condition for termination of services. Please contact me to make arrangements any time your financial situation changes.

Dual Relationships

Therapy never involves sexual, business, or any other dual relationships that could impair my objectivity, clinical judgment or therapeutic effectiveness or could be exploitative in nature. It is possible that during the course of your treatment, I may become aware of other preexisting relationships that may affect our work together, and I will do my best to resolve these situations ethically, but this may entail our needing to stop working together, depending upon the type of conflict. Please discuss this with me if you have questions or concerns.

Emails, Phone Calls, and Emergencies

For small administrative matters such as checking appointment times or changing them, you are welcome to email me at mramsay9595@gmail.com. I generally receive and return these emails within 24 hours with the exception of weekends. If you need to contact me between sessions about a clinical matter, please leave a message for me at 785-330-5688. I check my messages each day unless I am out of town. If I am planning on being out of town, I will let you know in advance. I will also let you know who I have covering for me if I plan not to take or respond to phone messages during my absence.

Emergency phone consultations of five minutes or less are normally free. Unless it is an emergency or urgent situation, longer issues may require a scheduled, in-person session.
If an emergency situation arises, please indicate it clearly in your message to me. If your situation is an acute emergency and you need to talk to someone right away, contact the closest 24-hour emergency psychiatric service: **Dial 911 or go to your nearest Emergency Room**.

Confidentiality
I follow the ethical standards prescribed by state and federal law, and my professional governing organizations. Discussions between us are confidential and you have the right to a confidential relationship with me. I am required by practice guidelines and standards of care to keep records of your counseling or therapy. All of our communication becomes part of yours and/or your family's clinical record. These records are confidential pursuant to certain legal and ethical limits and clinical parameters, and the HIPAA Notice of Privacy Practices provided to you. Within these limits, the information revealed by you during the course of therapy will be kept confidential. No information will be released without your written consent and authorization unless mandated by law.
Possible legal exceptions to confidentiality include, but are not limited to, the following situations:
• If you reveal information that indicates you are a danger to yourself or someone else necessitating a duty to protect or duty to warn.

• If you reveal information about child abuse, neglect, elder abuse or sexual exploitation.

• If you are in therapy as the result of a court order, unless otherwise stated in the court order.

• If I receive a subpoena or a court order to disclose information.

• If you provide written permission or direction to release your record.

Duty to Warn/Duty to Protect: If Ms. Ramsay believes that I (or my child if my child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Ms. Ramsay to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger.

By signing this Office Policies and Agreement form, you are giving consent for me to share confidential information with all persons mandated by law or for whom you have provided written permission and you are releasing and holding me and my staff harmless for any departure from your right to confidentiality that may result.

If you have any questions or concerns regarding confidentiality, please discuss them with me before signing this form.

Minors and Parents: Clients under 18 years of age who are not emancipated from their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their

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child's records. For all individuals, privacy in therapy is often crucial to successful progress and there can be long-lasting negative effects if a client feels their confidentiality has been breached. It is my clinical preference, if necessary, to release summaries, with general information about the treatment goals and progress of the child's treatment and his/her attendance at scheduled sessions. If I feel that the child is in danger or is a danger to someone else, I will notify the parents and/or appropriate authorities of my concern. It is also part of my practice to work with parents, in a consulting type of role, to help them learn ways they can be most helpful to their child at home.

Court Ordered Therapy: If you or your family's therapy has been ordered by a court, there are further limitations imposed on your rights as a client. These may include the decision to delineate the number of sessions available to you, or require your participation at a specified frequency. Under these circumstances, a report of your attendance and your progress in therapy may be required. I do not have control over any aspect of the rules or stipulation made by the court, but will take steps to protect your privacy to the extent possible.

Cancellations and Lateness

I hold your scheduled appointment time specifically for you and you alone. I also see a limited number of patients so that I can give you the focus and attention you deserve. It is extremely difficult for me to fill your last minute cancelled session on a short notice. Therefore, I charge $30 for appointments cancelled with less than 24 hours' notice unless we can find another time that week that works for us both. If we are able to do so, before the weekend, I will allow you to reschedule at no extra fee. If you are running late for your appointment, please phone or email me as soon as you can to let me know you will be late. If I do not hear from you by 15 minutes into your session, I will call to check on you and may assume you do not plan to attend your session. If you are late for your session, we will still end at our regular time so that I have time to prepare for my next appointments and I can be on time for them. **Medicaid clients cannot be charged late or cancellation fees

Payment and Financial Arrangements

My standard fee is $115 for a 45 - 50 minute individual session, and $130 for 60 minute sessions with individuals, families, or multiple individuals. Initial intakes are typically 90 minutes and are $150. If you are using insurance, my fee and your co-pay are based on the terms of your insurance plan. Please be aware that you may have a deductible for mental health benefits, and therefore, you may have to pay out-of-pocket at each session until your deductible is met. Payment for deductibles and copays are due at the time of your appointment. Both cash and credit cards will be accepted. **Medicaid clients filing insurance are only charged the rate that your particular MCO will pay, thus no out of pocket expenses are expected unless there is court involvement.

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Balances
I do not permit clients to carry a balance of more than two sessions and if you are unable to pay this balance, we will discuss whether it makes sense to pause your care or develop another strategy so that you can avoid incurring additional debt. Please let me know if any problem arises during the course of therapy regarding your ability to make timely payments.

Fee Reduction
I offer some lower fee slots, utilizing the attached sliding fee schedule based on income and family size. If my fee is a concern, please discuss it with me. If I am unable to accommodate your financial situation, I will provide you with referrals.

Court Involvement
If court involvement becomes necessary, including writing court reports, discussions with your attorney, and/or court appearance, please be advised that insurance does not cover my time, thus you will be billed at the hourly rate based on the calculated sliding fee schedule.

In cases of active litigation or post-divorce, anything released from my office in writing, goes to both parties/attorneys.

My attorney will be in attendance for any depositions and possibly court hearings, if they are contentious enough that we believe it to be necessary. You are responsible for any and all legal fees incurred as related to your case.

There are always serious concerns about releasing clinical notes, which are written by and for the clinician, to parents of minors. I believe it is potentially damaging to the child, the therapeutic relationship, and can often have farther-reaching consequences to the client. I prefer to release a clinical summary, if that is agreeable. That being said, I will of course follow the obligations outlined in the Kansas Health and Safety Code regarding the release of records.

Court/Deposition fees incurred include time for travel, preparation, and actual appearance time, billed at the stated hourly rate, with a **4-hour minimum charge. Payment is due and non-refundable 48 business hours in advance.** Any additional time spent on the day of the court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent.

I reserve the right to suspend services if there is an unpaid balance in your account.

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Notice of Privacy Practices

Introduction

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review it carefully.

For psychotherapy to be beneficial, it is important that you feel free to speak about personal matters, secure in the knowledge that the information you share will remain confidential. You have the right to the confidentiality of your medical and psychological information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health and psychological information. If you have any questions about this Notice, please let me know.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

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

I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes. The following should help clarify these terms:

- PHI refers to information in your health record that could identify you. For example, it may include your name, the fact you are receiving treatment here, and other basic information pertaining to your treatment.
- Use applies only to activities within my office and practice group, such as sharing, employing, applying, utilizing, and analyzing information that identifies you.
- Disclosure applies to activities outside of my office or practice group, such as releasing, transferring, or providing access to information about you to other parties.
- Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.
- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, with your written authorization I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you.
- Payment Your PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a billing service or providing you documentation of your care so that you may obtain reimbursement from your insurer.
- Health Care Operations are activities that relate to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities. For example, when I review an administrative assistant's performance, I may need to review what that employee has documented in your record.

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Written Authorizations to Release PHI
Any other uses and disclosures of your PHI beyond those listed above will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing.

Uses and Disclosures without Authorization
The ethics code of the NASW, Kansas State law, and the federal HIPAA regulations all protect the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This Authorization will remain in effect for a length of time you and I determine. You may revoke the authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that do not require your Authorization. I may use or disclose PHI without your consent in the following circumstances:

- Child Abuse – If I have reasonable cause to believe a child may be abused or neglected, I must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If I have reason to believe that an individual such as an elderly or disabled person protected by state law has been abused, neglected, or financially exploited, I must report this to the appropriate authorities.
- Health Oversight Activities – I may disclose your PHI to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about treatment and the records thereof, such information is privileged under state law, and is not to be released without 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 must be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

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Special Authorizations
Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

- Therapy Session Notes – I will obtain a special authorization before releasing your Therapy Session Notes. "Therapy Session Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.
- HIV Information – Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.
- Alcohol and Drug Use Information – Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment. You may revoke all such authorizations (of PHI, Therapy Session Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I 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.

Patient's Rights and Therapist's Duties
Patient's Rights: .

- Right to Receive Confidential Communications by Alternative Means – You have the right to request and receive confidential communications by alternative means and locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI in my records as these records are maintained. In such cases I will discuss with you the process involved.
- Right to a Paper Copy – You have the right to obtain a paper copy of the Notice of Privacy Practices from me upon request.

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.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at our next session, or by mail at the address you provided me.

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Acknowledgement and Agreement of Office Policies

I,___________________________________agree to abide by the items listed above in the Marci Ramsay, LSCSW, RPT-S Office Policies and Agreement Form.

____
Printed Client Name

___________________________________ ______________
Signature of Client Date

___________________________________ ______________
If client is minor, signature of Parent/Guardian Date

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Intake Packet

Instructions

1. Read ALL the forms.
2. Please do NOT sign the forms prior to the appointment as many must be witnessed by a staff member. These areas are highlighted for your convenience.
3. Complete as much as possible prior to your appointment, other than signatures.
4. Please bring a copy of your child's insurance card to the appointment.

If you have any questions regarding the paperwork you may call Marci Ramsay at 785-330-5688.

If you need to reschedule please call 785-330-5688.

I look forward to working with you and your child.

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Client Information

Child's Legal Name____________________________________Nickname________________

Date of Birth_____________________Gender__________Primary Language_____________

Name of School or Child Care Facility ____

Parent/Guardian Information

Parent or Guardian Name_________________________________Date of Birth____________

Relationship to Child_______________________Employer ____________________________

Address:____
Street City State Zip

Phone:______________________(cell phone) Ok to leave message? Yes / No

Phone:_______________________(other) Ok to leave message? Yes / No

Email________________________________Preferred contact method? ________________

Parent or Guardian Name_________________________________Date of Birth____________

Relationship to Child________________________Employer __________________________

Address:____
Street City State Zip

Phone:______________________(cell phone) Ok to leave message? Yes / No

Phone:_______________________(other) Ok to leave message? Yes / No

Email________________________________Preferred contact method? ________________

Who has legal custody of this child? ____

If separated or divorced, visitation schedule: _______________________________________

____

**If divorced or separated bring a copy of custody agreement to intake appointment.*

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Siblings in the home

Name DOB

____
____
____
____

Siblings not in the home

Name DOB

____
____
____
____

People in household, if different from above:

____

Others who are responsible for care of your child(ren)______________________________

____

Medical Information

Primary Care Physician______________Phone__________Last seen on__________

Is our child currently under the care of a physician for any medical conditions? If yes, please list. ______________________________

Current medications:

Name	Indication	Dose/Frequency	Start Date	Prescriber

Does your child have any allergies or bad reactions to medications or other substances?

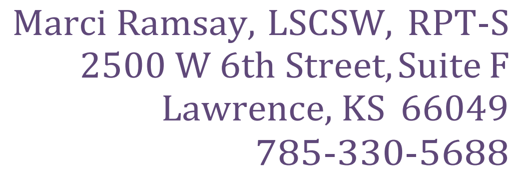
Yes / No If yes, to what?______________________________

Does your child see any other professionals for services, if so please list: (e.g. OT, PT, Speech Pathologist, etc)______________________________

Is this child a party to any legal action? (e.g. divorce, custody, child in need of care, current adoption, or protection from abuse) If yes, please describe:

____
____

Where did you learn of our services? ______________________________



Emergency Contact Name*____

Relationship __________________________

Phone__________________________

Address:____

Street City State Zip

*By providing this information you are authorizing Marci Ramsay, LSCSW, RPT-S to contact this person in emergency circumstances.

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Insurance Information

Responsible Person Subscriber

____
Last First MI

DOB:_________________________

Address:____
Street City State Zip

Employer:____

Relationship to Client:____

Insurance Provider____

Group #______________________________Policy Number ___________________________

Do you have secondary insurance?_____Yes_______No

Insurance Provider____

Group #______________________________Policy Number ___________________________

I authorize assignment of insurance benefits and payment to Marci Ramsay, LSCSW,RPT-S for covered expenses.

____ _______________
Signature Date

I understand that I will be responsible for any charges not covered by insurance regardless of the insurance policy. This includes copays and payments toward my deductible.

____ _______________
Signature Date

____ _______________
Witness Date

****Please bring a copy of insurance card to intake appointment.**

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Informed Consent

Guardian Initials

_____ I understand that Marci Ramsay is a master's level, licensed specialist clinical social worker (LSCSW) and Registered Play Therapist-Supervisor (RPT-S). Ms. Ramsay is qualified to conduct individual therapy with young children and families.

_____ I understand that as a licensed clinician, Ms. Ramsay is not permitted to share any personal or clinical information about me or my child, under HIPPA compliance, without my express written consent through signing a release of information.

_____ I understand that Ms. Ramsay is currently under supervision for case consultation with Dawn Wake, LSCSW, RPT-S (contact information available upon request). I further understand that this requires regular discussion of cases. However, it is my understanding that confidentially of the case specifics and identifying information will be maintained.

_____ I understand that Play Therapy services may be received at Ms. Ramsay's play therapy office, on site at the child care center/school, or in my home.

_____ I understand that I can request termination of services at any time.

_____ I understand that participating in Play Therapy services may involve both risks and benefits. Risks may include experiencing uncomfortable levels of feelings, being in touch with painful emotions, which may cause me or my child to feel worse, and personal growth sometimes requires changes that may be uncomfortable or unexpected. Benefits may include experiencing an increase in positive responses to difficult situations, determining my child's strengths and goals, and enjoying increased satisfaction with the quality of life.

_____ I understand that Ms. Ramsay is a mandated reporter, which means that any known or suspected abuse or neglect will be reported to the local DCF office (previously SRS). In addition, should my child or I express an intention to hurt ourselves or others, a report will be made with local authorities to ensure safety.

_______________________________ Parent/Guardian Signature

____________________ Relationship to child

____________ Date

_______________________________ Therapist Signature

______________ Date

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CONSENT FOR TREATMENT OF A MINOR CHILD

We/I, ___________________________________, parent(s) and/or guardian(s) of the minor child(ren) _____________________________________, give Marci Ramsay, LSCSW, RPT-S full and unconditional authority to proceed with a clinical evaluation and treatment as her judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child(ren). We/I have the legal power to consent to mental health assessment and treatment of said minor child(ren). It is clearly understood that Marci Ramsay, LSCSW, RPT-S is hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that her duties are performed with standard care and responsibility to the best of her professional ability.

____
Printed Name(s)

____
Parent(s)/Guardian(s) Signature

____
Relationship to Child Client

____
Date

****In cases of separation or divorce:** I have provided legal documentation (divorce decree or current court orders) regarding conservatorship and my legal right to consent to treatment for my child.
_____ (Parent Initial)

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Consent for Assessment and Video Recording

Marci Ramsay, LSCSW, RPT-S is committed to providing the best services possible. As part of my service, I periodically assess parent and child strengths. Comprehensive results are used to note individual case progress and program evaluation. Currently utilized are the Vanderbilt Assessment Scales, Screen for Child Anxiety Related Disorders (SCARED), Adverse Childhood Experiences Survey (ACES), in some cases, the Marshak Interaction Model (MIM).

In addition, consultation and mental health services often employ the use of a video camera in order to provide competent assessments and intervention techniques. Results of assessments and video recordings are used to guide my interactions with you and your child. They may also be used in consulting with other professionals for the purpose of improving services for your child, or as teaching tools. In all cases your identity and your child's identity will be protected and confidentiality will be kept. All video recordings will be destroyed upon case closure.

Failure to give assessment/video permission will not change your ability to access Play Therapy services for your child.

By signing, you are giving permission for your child to participate in the assessment and video recording process as indicated below. If you would like to see a copy of any assessments or video recordings, you are able to request these at any time.

____
Child's Name

____
Parent/Legal Guardian (please print name)

______________________________________ ____________________
Signature of Parent/Legal Guardian Date

______________________________________ ____________________
Signature of Witness Date

☐ Assessment

☐ Video Recording

**Mark only if you do not wish to participate in assessment/video.

☐ Opt Out ______________
Initials

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Authorization to Release Information

I, ________________________________, the undersigned, give permission to Marci Ramsay, LSCSW, RPT-S to release and provide to:

____
(Name)

____
(Address)

____
(Phone Number)

Regarding services provided to ____
Child's Name

DOB:_________________

the following information (check all that apply)

____ attendance in therapy

____ diagnosis

____ treatment plan

____information relevant to coordinating care

____when treatment is terminated and why

____other (please explain in detail) _______________________________________
____

I understand that that this release is valid for a period of 120 days. I further understand that I may revoke this authorization at any time in writing.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

________________________________ ______________
Signature **Date**

Marci Ramsay, LSCSW, RPT-S
2500 W 6th Street, Suite F
Lawrence, KS 66049
785-330-5688

Authorization to Release Information

I, _________________________________, the undersigned, give permission to Marci Ramsay, LSCSW, RPT-S to release and provide to:

____
(Name)

____
(Address)

____
(Phone Number)

Regarding services provided to ____
Child's Name

DOB:_________________

the following information (check all that apply)

____ attendance in therapy

____ diagnosis

____ treatment plan

____information relevant to coordinating care

____when treatment is terminated and why

____other (please explain in detail) ____
____

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________________________________ ______________
Signature **Date**

Marci Ramsay, LSCSW, RPT-S
2500 W 6th Street, Suite F
Lawrence, KS 66049
785-330-5688

SLIDING SCALE FEE AGREEMENT

I, ____, certify that I do not have health insurance (or certify that I will not / cannot utilize any health insurance for services rendered by the Marci Ramsay, LSCSW, RPT-S and/or due to my current financial situation, I cannot afford the full fee rate of $115/session. I therefore, request that my fee be adjusted. I have estimated my expenses using the Sliding Scale Fee Guidelines for this purpose. My current monthly income is currently insufficient to cover my monthly expenses and therapy at the rate of $115/session. This is also true of my total household income, if living with a partner. Therefore, I understand that the fee for services with Marci Ramsay, LSCSW, RPT-S will be _____$0_____/session and is payable at the time of each session (unless other arrangements are made in advance). I further understand that I will not be charged for any appointments that are cancelled at least 48 hours in advance. I understand that appointments not cancelled at least 48 hours in advance are subject to a “Late Cancellation” or “No Show” charge of my contracted rate above. I understand that I am solely responsible for all these charges as they apply, as well as, the costs associated with collecting these charges. I agree to notify Marci Ramsay, LSCSW, RPT-S of any substantive changes in my financial situation (e.g., 10% increase or decrease in income) within 30 days of the change, and understand the fee may change according to my updated financial situation. I further acknowledge that my therapist will periodically verbally review my financial status with me, approximately every 8-10 consecutive weeks, in order to reassess eligibility. A continuance of Sliding Scale benefits is not guaranteed and is subject to modification and/or elimination at the sole discretion of the Marci Ramsay, LSCSW, RPT-S.

____ ____________________
Client Print Name Date

____
Parent/Guardian Signature

____ ____________________
Therapist Signature Date

Marci Ramsay, LSCSW, RPT-S
2500 W 6th Street, Suite F
Lawrence, KS 66049
785-330-5688

Sliding Fee Schedule

	Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level		**At or Below 100%**	**125%**	**150%**	**175%**	**200%**	**Above 200%**
Family Size	**Rate**	**Nominal Fee**	**60%**	**70%**	**80%**	**90%**	**100%**
	45 min	**$57**	**$69**	**$80**	**$92**	**$103**	**$115**
	60 min	**$65**	**$78**	**$91**	**$104**	**$117**	**$130**
	Intake	**$75**	**$90**	**$105**	**$120**	**$135**	**$150**
1		0-$11,880	$11,881-$14,850	$14,851-$17,820	$17,821-$20,790	$20,791-$23,760	$23,761+
2		0-$16,020	$16,021-$20,025	$20,026-$24,030	$24,031-$28,035	$28,036-$32,040	$32,041+
3		0-$20,160	$20,161-$25,200	$25,201-$30,240	$30,241-$35,280	$35,281-$40,320	$40,321+
4		0-$24,300	$24,301-$30,375	$30,376-$36,450	$36,451-$42,525	$42,526-$48,600	$48,601+
5		0-$28,440	$28,441-$35,500	$35,501-$42,660	$42,661-$49,770	$49,771-$56,880	$56,881+
6		0-$32,580	$32,581-$40,625	$40,626-$48,870	$48,871-$57,015	$57,016-$65,160	$65,161+
7		0-$36,730	$36,731-$45,913	$45,914-$55,095	$55,096-$64,278	$64,279-$73,460	$73,461+
8		0-$40,890	$40,891-$51,113	$51,114-$61,335	$61,336-$71,558	$71,559-$81,780	$81,781+