Informed Consent and Counseling Agreement

Katherine Smith, Licensed Clinical Marriage and Family Therapist

Thank you for giving me the opportunity to serve you in your counseling needs. I pledge to give you the best care that I can and will deliver to you the highest quality of service. In order to meet your needs the following information is provided for your consideration. Please read this carefully and ask any questions that you may have.

Credentials – I am a Licensed Clinical Marriage and Family Therapist in the state of Kansas, and have a Masters Degree in Counseling. I am not a physician and do not have authority to prescribe medication.

Benefits and Risks – Any time individuals seek therapy to work on difficulties within themselves or in their personal relationships, there are potential benefits and risks. Benefits may include the ability to handle specific concerns and/or interpersonal relationships in a healthier way. Clients may also gain a greater understanding of personal, interpersonal, or family issues. This new understanding may lead to greater maturity and happiness as an individual or family. There may also be other benefits that come as clients work at resolving specific concerns.

However, therapy is also sometimes challenging and uncomfortable. Reviewing and resolving unpleasant issues may result in intense feelings of anxiety, anger, depression, or frustration. As clients work to resolve personal issues or issues between family members, peers or other persons, they may experience discomfort and an increase in conflict. Changes in relationships that were not originally intended may also result.

I will discuss with each individual/family the benefits and risks involved in their specific situation. Clients are encouraged to discuss with me concerns they may experience at any time.

Confidentiality – It is my policy and desire to protect the rights of my clients to confidentiality as defined in State and Federal statutes. All staff at Lifeline Counseling Center have been educated in the principles of confidentiality. You may rest assured that your records are being kept, handled, and monitored in the most professional ways possible. No information from your records will be released to anyone without your prior written consent. Exceptions to this include:
-suspected abuse or neglect of someone;
-duty to warn of homicidal intent;
-civil detention to prevent suicide;
-when ordered by a court of law;
-when either you or I initiate legal action regarding the counseling process;
-when I am in a civil or criminal lawsuit pertaining to my counseling practice;
-when you sign a release for disclosure of the contents of your records or of pertinent needs/progress to any person such as a doctor or other co-treater, family member or pastor;
-when I bill third party providers such as an insurance company, Employee Assistance Program, or a church;
-occasional collaboration or consult with professional colleagues (these persons are also required to keep your information confidential);
-Parents have a right to have a reasonable account of their minor child's therapy. Occasionally when a child/adolescent reveals information in therapy, they wish it to remain confidential. Usually their request will be honored unless it involves dangerous behavior such as drug/alcohol use, risky sexual behavior, suicidal ideation, or running away;

-If you and your partner decide to have individual sessions as part of the couple's therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything that you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Court Fees – Should it be requested or required that I appear in court, there will be a $250 court appearance fee, as well as a $120/hourly fee assessed for my time. Additional fees may apply for copying of files or report writing.

Scheduling of Appointments – I will make every effort to schedule your appointments at times most convenient for you. My sessions last approximately 50 minutes. It is your responsibility to arrive on time. If you are running late please call and let me know. **If you have not called and are not here by 15 minutes past the scheduled start time, I will cancel the appointment and bill you the full fee for the session. I must have 24 hours advance notice if you cannot attend your scheduled appointment.**

How to reach me – Should you need to reach me, please call 913-764-5463. If I do not answer, please leave a message with your phone number. Use the emergency number on my LifeLine voice mail only if your call is urgent and demands immediate action. Most calls do not warrant the emergency number.

My voice mails are forwarded to my private number to ensure that I am available when you need to reach me. However, I may not immediately be able to speak with you when you try to contact me if it is between the hours of 9am and 8pm due to being in sessions with other clients. I will gladly return your call as soon as I am able. On occasion you may experience a time when speaking to me briefly outside a session would be helpful. As I receive notice of your need and am able to respond, I can provide at most two ten-minute phone crisis sessions per week without charge. Phone calls lasting 15 minutes or more will be billed in 15 minute increments at my standard hourly fee.

Children – Please do not bring your children unless they are a part of our session. I also ask that you do not leave children unattended in the waiting area. If you have any questions or concerns regarding children, please discuss those with me.

Record Keeping – I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. Under the provisions of the Health Care Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

On occasion I may be asked to fax or email information regarding your treatment. This request could be made by an insurance company or another health care provider.

I **authorize** the fax or email transmission of information from my records.

_____
Client initials

I **do not** authorize the fax or email transmission of information from my records. _____
Client initials

If I am away from my office, I may use a cell or cordless phone to communicate with you. These calls are not always guaranteed to be 100% secure. I need permission to talk with you on a cell or cordless phone.

I **authorize** phone calls via cell or cordless phone. _____
Client initials

I **do not** authorize phone calls via cell or cordless phone. _____
Client initials

Privacy Notice – Please read the Privacy Notice, which is mandated by federal law and the Health Insurance Portability and Accountability Act (HIPAA), and initial here _____. The notice explains HIPAA and how it applies to your personal health information. By initialing this agreement you are acknowledging the receipt of the privacy act.

Insurance Billing – I am a provider on some insurance panels, please be advised of the following:

1. Some, but not all, insurance companies will pay a portion of counseling fees. I cannot guarantee that your company will do such.
2. You are responsible for knowing your insurance benefits.
3. I will bill your insurance company in a timely manner and will expect payment in such. Most companies reimburse within 30 days of receiving a claim. If your insurance company delays payment, you may be asked to contact the company to expedite payment.
4. You are expected to make applicable co-payments at the time of each visit.
5. Your insurance company will not pay for any missed appointments. **You are responsible for paying my fee for these according to the rate your insurance company has contracted with me.**

Finances - My fee per session is **$120 for the first session and $90 for all following sessions.** Counseling fees are due and payable before the session begins. If you desire any other arrangement, please talk to me in advance. I accept cash, check, Discover, MasterCard and Visa and some HSA cards. There is a $15 charge for a returned check.

My signature below indicates that:

1. I have read, understand, and agree with the therapist's policies and give informed consent to receive therapy services.
2. I understand that there can be risks and benefits associated with therapy. I also understand that no promises have been made to me as to the results of treatment.
3. I understand that I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session rather than by phone.
4. I acknowledge receipt of a copy of this Informed Consent.
5. I authorize the release of my/our name only to our referral source to thank them for our referral.
6. I agree to allow disclosure of necessary information for the processing of insurance claims on my behalf.

7. I have read and agree to the above Finance and Insurance Billing sections. I agree to pay $_____(fee/copay; *circle one*) I also agree to pay for missed appointments or for appointments I cancel without giving the required advance notice.

Client Signature _____ Date_____

_____Date_____

Therapist Signature _____Date_____
Katherine Smith, LCMFT