KMI Counseling LLC

Informed Consent for Assessment and Treatment

Welcome to my counseling practice (KMI Counseling, LLC). I am committed to helping you toward whatever your outcome is for our time together. A counseling situation offers a unique relationship between the two of us. In order that we start our relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services. The following information is meant to answer any questions you may have regarding my policies and procedures. *Please do not hesitate to ask any questions regarding your treatment goals, procedures, or any other concerns you may have.*

Background and Services. - I am an Arizona Licensed Professional Counselor, and I am certified by the National Board of Certified Counselors. I am in the office Tuesdays from 10:00am until 6:00pm and Fridays 10:00am-6:00pm by appointment only. Evening appointments are also available Monday and Wednesday.

Although there may not be someone to greet you when you arrive, please feel confident that you will be seen at your scheduled appointment time.

I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

Availability of Services.- Again, I am in the office Tuesdays from 10:00am- 6::00pm and Fridays 10:00am-6:00pm and evenings Monday and Wednesday by appointment only.

My practice does **not** have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact – 480-784-1500 or Mercy Maricopa– 602-222-9444). Established clients with an urgent need to make contact may call me on my mobile phone, but an immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Financial -Payment is expected at the time the service is rendered unless other arrangements have been made. By signing this document, you are agreeing to pay for the services rendered at the end of each session. Fees are based on 60-minute clinical session hours**. Currently, the fee for 60-minute individual session is $140.00, ____ (please initial).** In addition to the basic session, there may be other fees for additional services such as psychometric testing, telephone counseling, books and materials, etc. I reserve the right to change my fees with 30 days' notice and to use the services of a third-party collections service, when necessary. Refunds are not made after the services have been rendered. You have the right to be informed of all fees that you are required to pay and my refund and collection policies. Please discuss these with me if you have any concerns.

Appointments – Regular attendance at your scheduled appointments is one of the keys to a successful outcome in therapy. I reserve 60 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. ***You will be billed the full rate for the appointments you fail to cancel in accordance with this policy. (_____please initial). Repeated late cancellations or missed appointments may result in termination of treatment. In addition, if you arrive more than 15 minutes late to an appointment, without notifying my office, I will assume you are canceling within 24 hours and the cancellation rates will apply. Outside of 24 hours there is complete flexibility.***

Appointment availability varies with the client load at the time. High demand appointments (off hours, late afternoons, and weekends) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

Purpose, limitations, and risks of treatment. – Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through possibly tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues.

Treatment process and rights. - Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the issue(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

Our relationship. –The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions. This includes any and all social media contact. The ACA Code of Ethics prohibits Counselors from engaging in virtual relationships with individuals with whom they have a counseling relationship; this includes Facebook, LinkedIn and other social media. _____ (Please initial).

The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is always protected and maintained.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is *never* my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

Confidentiality and Technology - You may choose to use technology in your counseling sessions. This may include but is not limited to VSEE, telephone, email, or text. Although I do not do online counseling, there are times we may communicate via electronic technology. There is always the possibility that unauthorized persons may attempt to discover your personal information. I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in regard to counseling sessions, appointments etc. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should you have concerns about the safety of your email or texts, I can arrange alternate communication mediums with you. If you initiate texting or email communication with me, you are authorizing your approval of this medium for communication. _____ (please initial).

You have the right to request confidential communications. You have the right to request that we communicate with you about treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email or mail. We will not ask you the reason for your request. We will accommodate all reasonable requests.

What number would you like to be contacted at? _____

Is it okay to leave a message at this number? yes____ if no ___ leave message at_____ .

Insurance - Some insurance providers and company flex plans provide full or partial coverage for mental health services. Your insurance or flex plan is a contract between you and your insurance company or corporation. It is not an agreement between the insurer and my practice. I will be happy to furnish you with a receipt that can be used for filing your own insurance. Signing this form authorizes, KMI Counseling LLC to release your DSM-IV diagnosis and for it to be printed on your Health Claim Form in order for you to obtain possible reimbursement. In all cases however, payment for services is ultimately the responsibility of the client, not the insurance company. Once again, please discuss this with me if you want to use this receipt option.

If you are over 65 or otherwise eligible for Medicare you should understand that Licensed Professional Counselors are not currently eligible providers under this program. Medicare clients are required to pay the fees out of pocket.

Privacy, confidentiality, and records - Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child or vulnerable adult abuse or neglect is involved. I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While *no identifying information* is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods. During times when I am out of town or otherwise unavailable, I will typically have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records and our time together, including personally identifiable information, to this on-call therapist to facilitate the coverage of your care in my absence.

There are also numerous other circumstances when information may be released including when disclosure is required by the Arizona Board of Behavioral Health Examiners, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. The *HIPAA NOTICE OF PRIVACY PRACTICES*, posted in this office and available upon request, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the *HIPAA NOTICE OF PRIVACY PRACTICES* may be revised. Any changes to these privacy practices will be posted in my office, but you will not receive an individual notification of the updates.

It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.

_____ Initials	**I have read the *HIPAA NOTICE OF PRIVACY PRACTICES*, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the *HIPAA NOTICE OF PRIVACY PRACTICES* is incorporated by reference into this agreement.**

In the event of my death or incapacity, the records for my clients that are actively receiving services (seen within the last month) will be given to one or more local behavioral health professionals to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a "records custodian" which may be an individual or company. The custodian will be responsible for satisfying records request and destroying records when the legal timeframes for records retention are satisfied.

Right to request confidential communications - You have the right to request that we communicate with you about treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests.

During times when I am out of town or otherwise unavailable, I will typically have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records and our time together, including personally identifiable information, to this on-call therapist to facilitate the coverage of your care in my absence.

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Consent for evaluation and treatment. – Consent is hereby given for evaluation and treatment under the terms described in this consent document and the *HIPAA NOTICE OF PRIVACY PRACTICES*. I acknowledge that I have received a copy of this informed consent agreement and the *HIPAA NOTICE OF PRIVACY PRACTICES (upon request)*. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided.
In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature:_____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor: _____ DOB: _____ Relationship: _____

For office use only - verification that client has read and understands informed consent document Authorized Representative: _____ Date: _____