Informed Consent and Client Service Agreement

Welcome to Kairos Counseling. This document contains important information about our professional services and business policies. It also contains summary information about HIPAA, a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Because application is important to change, we may develop projects or activities you can do outside the session to further promote your healing in addition to talk therapy. These activities can be very helpful to insure the changes you experience in the sessions translate into your life outside of the session.

At the beginning of counseling, we will discuss the presenting concern, clarify your needs, treatment options & goals, possibility of a diagnosis, and explore possible referral to another professional (a medical doctor, for example). If beneficial, permission to engage family members to collaborate may be asked. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. Please ask any questions you have about procedures and theory of counseling being used as soon as they arise. In order for psychotherapy to be effective, it is vital to have a therapeutic relationship with the provider. You should know within the first 6 session if the therapeutic relationship is helpful. Please feel free to ask for a referral to another provider if your needs are not being met.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time agreed on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, please provide 24 hours' notice. **If you miss a session without canceling, or cancel with less than 24 hour notice, the policy is to collect the amount of $75.00** [unless it is agreed that you were unable to attend due to circumstances beyond your control, there is a one-time courtesy waiver]. If it is possible, another appointment time will try to be scheduled. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. _____ Initial here

PROFESSIONAL FEES

The standard fee for the initial intake is $150.00 and each subsequent session is $130.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, electronic payment, or insurance with copay. Any checks returned to the office are subject to an additional fee of up to $25.00 to cover the bank fee incurred. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment._____ Initial here

In addition to weekly appointments, a prorated (a breakdown of the hourly cost) fee will be billed for any other professional services you may require such as report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other services you may request. If you anticipate becoming involved in a court case, it is recommended to fully discuss the situation before you waive your right to confidentiality. If your case requires the therapist's participation, you will be expected to pay for the professional time required even if another party compels the testimony.

INSURANCE

You should also be aware that most insurance companies require you to authorize the provision of a clinical diagnosis. Sometimes, additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases) are required. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, Kairos Counseling has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. You will be provided a copy of any report submitted, if you request it.

PROFESSIONAL RECORDS

We are required to keep appropriate records for the period of 7 years after termination of services and maintained in a secure location. We use a cloud base program designed to meet or exceed HIPAA requirements. The records consist of brief notes indicating your presence, reasons

for seeking therapy, goals, and progress for treatment. They may also contain a diagnosis, topics discussed, medical, social, and treatment history, billing, along with records sent to and received from other providers. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your therapist or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider upon your written request.

CONFIDENTIALITY

Providers within Kairos counseling may discuss cases with each other while seeking guidance and accountability. Otherwise, all information shared will be confidential unless there is a release of information form signed by you. At times it will be necessary to consult with other medical professionals in order to provide the best possible care; however, no identifiable information will be shared. The following are limits to confidentiality: if the client poses a risk to self and/or others, any known or suspected incidences of abuse, neglect, or exploitation of children or elderly and incapacitated adults. By law, counselors have a duty to report these concerns to the authorities, the local police department or Virginia Department of Social Services. In rare situations, our records may be subpoena by the courts.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that we can share whatever information considered necessary with a parent. For children 14 and older, an agreement between the client and the parents allowing general information about treatment progress and summary upon completion of therapy will be needed. All other communication will require the child's agreement, unless there is a safety concern (see Confidentiality), in which case every effort to notify the child will be made ahead of time.

CONTACTING ME

Therapists are often not immediately available by telephone due being with clients or otherwise unavailable. At these times, you may leave a message on the confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from your therapist or s/he are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact RACSB Emergency Services 540-373-6875, 2) go to the nearest Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering for the practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, please talk with your therapist about your concerns. Such comments will be taken seriously and handled with care and respect. You may also request a referral to another therapist and you are free to end therapy at any time. You have

the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about specific training and experience. You have the right to expect that your therapist will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement, Notice of Privacy Practices, and agree to their terms including the release of information to insurance companies, if applicable.

_____

Signature of Client or Personal Representative

_____ _____

Printed Name of Client or Personal Representative

Description of Personal Representative's Authority

Date _____

Signature of Witness: _____Date: _____