PROFESSIONAL SERVICE AGREEMENT

Informed Consent for Psychotherapy Services

HISTORY

Kathryn N. Walden Counseling Services, LLC welcomes you to the private practice of Kathryn N. Walden.My clinical specialities and areas of professional interest include anxiety, trauma recovery, addiction, life transitions, resiliency within family systems, relationships, heartbreak, and depression. I have worked in academic as well as agency settings throughout the years while remaining dedicated to maintaining standards of professional conduct and confidentiality. I am licensed by the state of Florida as a Licensed Mental Health Counselor, LMHC MH 20857.

TREATMENT APPROACH

My approach is warm, empathetic and solution-focused. You hold the answers and are the expert in your own life; with therapeutic guidance and direction, I am here to be the catalyst for change and personal growth. We will work together as a team to identify opportunities and growth in the midst of chaos, regulate emotions during life's difficulties, find purpose and meaning in your life, and intentionally create goals that will allow for positive change to occur. My treatment approach is integrative and uses the most powerful and scientifically based treatment methodologies in order to tailor to the specific needs of your treatment plan. It has been my experience that Cognitive-Behavioral Therapy (CBT) combined with mindfulness-based and solution-focused based therapies have proven to be most effective.

SESSIONS

Your intake appointment will last approximately 50-60 minutes and will cover treatment practices, philosophy, assessment, and an individualized plan for treatment. We will work together to create a unique treatment plan aimed to increase self-confidence, gain clarity, and target your personalized goals. Therapy may last two months to two years. It is typically a weekly commitment where we will continue to review your treatment plan and adjust goals as they evolve.

WELCOME

[1]This document is intended to inform you of our policies, state and federal laws, and your rights as a client, but may not be comprehensive. If you have questions or concerns, please ask at any time. It is your duty and responsibility to understand the scope of psychotherapy as a professional service tailored to your personal needs, goals, and your client rights. Creating a solid and trusting therapeutic relationship is essential in ensuring a successful outcome; I encourage you to speak your mind, trust the process, and let the healing begin.

Please complete the following identifying information and ask questions if necessary.

Client Name: _____

Address: _____

Phone: _____ Email: _____

Home Cell Work

Emergency Contact: _____ Phone: _____

Relationship to Client: _____

Client Date of Birth/Age: ___/___/____ _____

Parent/Guardian Name (if under 18): _____

Parent/Guardian Signature (if under 18): _____

Reason for seeking counseling:

_____

I

Today is the day to reach out, tomorrow is the day to feel better.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for:

a) Information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Florida state law, we are obligated to report this to the Department of Children and Family Services,

c) Where you sign a release of information to have specific information shared with treatment team members, such a doctor or psychiatrist,

d) Threat of harm or danger to oneself or others

e) Information necessary for case supervision or consultation, or

f) When required by law.

Kathryn N. Walden Counseling Services is not a crisis facility and does not provide emergency services. If a client or a client's guardian believes a client is in danger of immediate harm to self or others, call 911 immediately. In the event of hospitalization, please notify me as soon as possible in order to coordinate aftercare services.

Text messages and phone calls outside of session are permitted, but confidentiality could potentially be at risk and I cannot guarantee a timely response. Clinical and personal discussions must be held in session; please reserve phone calls and text messages for appointment cancellations and changes. You may connect with me via social media on a professional level and personal information is not to be shared for your own protection.

Client Signature : _____

Date: _____

Parent/Guardian Signature (if under 18): _____

Date: _____

1100 Town Plaza Court Suite 2020 Winter Springs, FL 32708
Phone: 407.450.3849
Email: knwcounseling@gmail.com
Web: www.knwcounseling.com

FINANCIAL AND INSURANCE POLICIES

This section covers the business aspect of the therapeutic relationship. Despite the fact that therapy fosters a uniquely close and safe environment, financial services must be addressed. Payment will be collected at the beginning of each session after the initial intake, whether it be by cash, credit card, or check. It is your responsibility to review and understand the fee schedule, and to ask any questions that you may have at your initial session.

FEES

Individual counseling sessions are $95 for 45-50 minutes. The initial session/intake assessment fee is $100. Other fees for services provided are listed on the Fee Schedule, which is provided for you to keep. Payment is due at the time of service rendered. **If you need to cancel/ reschedule an appointment, please give 24 business hours advanced notice, otherwise you will be billed at the hourly rate with the credit card you have authorized us to have on file.**

INSURANCE

Kathryn n. Walden counseling Services, LLC is currently accepting Cigna insurance and payment through check, cash, or credit card.

CREDIT CARD POLICIES

Payment is due at the time of service. I accept cash, checks, as well as credit card payment. If you would like to pay by credit card, you may place a card on file for ease of weekly payment. Additionally, this form requests authorization for us to maintain a credit card on file for missed appointments.

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CREDIT CARD AUTHORIZATION

I, _____, give Kathryn N. Walden Counseling Services, LLC, the authorization to charge my credit card $95 for each missed counseling session where 24 hours' notice is not given.

_____ (initial) I would like Kathryn N. Walden Counseling Services, LLC to place the following credit card on file for my regular counseling sessions. I understand that my card will be charged at the time of service unless I have requested an alternate form of payment be utilized.

_____(initial) I do not wish to have a card on file for regular use. I will pay cash or check and agree to pay $95 for any missed session.

Credit Card Number: _____

_____ _____ _____

Expiration Date Zip Code CCV

Name on card: _____

COLLECTION OF FEES

In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed.

I, _____, have received a copy of my fee schedule.

Client/Parent or Guardian Signature

I sincerely appreciate your cooperation and at any time you have any questions regarding fees, balances or payments please feel free to ask.

I agree to the terms set aside in the above section entitled "Financial Policies," and I understand that I may request a review of this document and the policies contained herein at any time during the course of treatment.

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Client/Parent or Guardian Signature: _____

Date: _____

CANCELLATION POLICY

24 hours' notice is required to cancel or reschedule an appointment. In the event of a missed appointment without 24 hours' notice, you will be billed at the hourly rate with the credit card you have authorized us to have on file.

EMAIL DISCLAIMER

For your convenience, email may be used to send receipts, appointment reminders, and/or information related to your PHI (personal health information). Using email comes with risks related to the safety of your data, please use you discretion in agreeing to the following.

EMAIL RELEASE

I agree to use email for correspondence related to appointment reminders, PHI, and receipt of payment to the following email address: _____

1100 Town Plaza Court Suite 2020 Winter Springs, FL 32708
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CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that _____ be treated as a therapy client by Kathryn N. Walden Counseling Services. Parent involvement is a necessary component of the treatment of children and adolescents. Parents must agree to attend sessions as requested by the therapist, and to follow through on treatment plans recommended by the clinician to the extent that they are able.

It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours, and we ask for your cooperation to provide timely treatment for you and your children. A school note can be provided to your child upon request. This consent to treat my child expires at the end of treatment or if revoked in writing.

Signature of Parent or Guardian: _____ Date: _____

Signature of Client: _____ Date: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: January 2022

Kathryn N. Walden Counseling Services is committed to maintaining client confidentiality. We will only release health care information about you in accordance with federal and state laws and the ethics of the social work profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. This includes, but is not limited to:

- Information you and/or your child or children report about physical or sexual abuse. By Florida State Law, we are obligated to report child and elder abuse to the Department of Children and Family Services.
- Information that informs us that you are in danger of harming yourself or others, we must also report this information to the proper authorities.

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- Information to remind you of, or to reschedule, appointments, or treatment alternatives.
- Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

CLIENT RIGHTS

- Right to request how we contact you
    - It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

- Right to release your medical records
    - You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

- Right to inspect and copy your medical and billing records.
    - You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request or offer to provide a treatment summary instead of full records. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

- Right to add information or amend your medical records.
    - If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you

disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

- Right to an accounting of disclosures.
    - You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

- Right to request restrictions on uses and disclosures of your health information.
    - You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

- Right to complain.
    - If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

- Right to receive changes in policy.
    - You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

COORDINATION OF TREATMENT

It is important that your health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please note, you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

Signature(s)_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have read and received a copy of the Notice of Privacy Practices and Client Rights

Signature(s)_____Date_____

May we contact you at home (circle one)? yes no

May we contact you at work? yes no

May we contact you by cell phone? yes no

Where may we contact you _____?

1100 Town Plaza Court Suite 2020 Winter Springs, FL 32708
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FEE SCHEDULE

EFFECTIVE DATE: January 2022

Individual therapy	In-Person: $125.00	Online: $95.00
Family or Couples counseling	In-Person: $200.00	Online: $170.00

Minimal phone consultation, texting, or email. No charge if under 15 min.

Please review privacy practices and see above as Review of Records and/or session rate may apply depending upon the content of the communication. Communication of a clinical nature is charged at the contracted hourly rate while business/financial communication is at the Review of Records rate.

Extensive Phone Consultation	$95.00 per hour
Missed appointment	Hourly Rate

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GOOD FAITH ESTIMATE

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

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