Holly Maddy LLC and Associates

328 Thomas More Parkway
#102
Crestview Hills KY 41017-3488
(859) 431-6333

1. Informed Consent for Psychotherapy

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Purpose and Background

The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where
appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any
diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I
have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.
While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not
precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or
procedures provided by Holly Maddy, LLC. Potential benefits, risks and limitations of psychological services have been explained to
me as well as alternative procedures or interventions if they exist..

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

8. Also, as explained in greater detail on the "Fee agreement" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

HIPPA

I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I
am aware that the Federal Government has a very broad policy concerning the protection of my health information. I
acknowledge that I have been offered a full printed copy of Holly Maddy, LLC “Notice of Privacy Practices”, that were effective of
as their start of business on April 21, 2008. I acknowledge I was offered this policy statement on the date indicated by my signature
below.

Attendance

I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will
produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to
discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of
concern.
I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly
canceled will be considered a “No Show” and will be billed to me at the rate of $75 per missed appointment. Further, I understand
that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment
without sufficient (24 hour) notice.

Contact Information

The office address for Holly Maddy, LLC is: 328 Thomas More Parkway #102, Crestview Hills, KY 41017. I understand that for routineappointments and information I may call (859) 431-6333. If no one is available to take my call, I can leave a confidential voicemailand my call will be returned as soon as possible by my therapist or administrative assistant (1-2 business days). If I have an after-hours crisis or need assistance more quickly I can call (513) 281-CARE, or 911. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room if I am unable to contract for safety.

Complaints Procedure

If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with
my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have
been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through the KY
Board of Social Work/ KY Board of Licensure for Marriage and Family Therapist 125 Holmes Street, Suite 310 Frankfort, KY 40601. Kentucky Board of
Licensed Professional Counselors | 911 Leawood Drive | Frankfort, KY 40601

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree
with the contents of this Consent to Treatment.
I release and hold harmless Holly Maddy, LLC, and its staff and agents from any action or liability arising out of my participation in
treatment.

If the client is a minor, I give voluntary permission and consent for my child to receive
psychological services from Holly Maddy, LLC. My signature also verifies my right to give such permission.

Signature:

- [ ] Self

- [ ] Parent or Legal Guardian

Date of Signature: