KIMBERLY KLINE, MA, LPC
Licensed Professional Counselor#14177
1721 West Plano Parkway, Suite 216
Plano, TX 75075
Ph.214-543-5977

INITIAL SESSION CONTRACT

I **_____,** am attending counseling sessions voluntarily and understand that my therapist is available 24 hours a day to me (with some limitations which we have or will discuss) and she has given me referrals for inpatient evaluation and care and permission to go to the nearest emergency room if I feel I am in immediate danger. We will discuss and I will be knowledgeable of the situations in which I may need to call the suicide hotline. (214.828.1000) or 988.

_____ I understand that my therapist may terminate our therapeutic relationship if I fail to appear for three sessions or if I fail to comply with recommendations regarding my personal safety. I will be given notice of termination. My therapist will refer me to other sources of therapy at that time.

My therapist has my permission to seek peer supervision in an anonymous way in their peer supervision group. I understand that I may call the Texas Board of Licensed Professional **Counselors at Complaints Management and Investigation Section, PO Box 141369 Austin, TX.78714-1369**, in regards to any complaints I may have regarding my therapist and/or my counseling experience with her/him.

____I understand that if I do not give 24 hours notice to my therapist prior to canceling my appointment, on more than one occasion, I will be charged $90 for the missed appointment. I understand that Your Living Well, PLLC charges $190 for an initial session and $150 for any following sessions. Sessions are to be 45 to 55 minutes in length.

I understand that I am being given a Good Faith Estimate of possible costs based on typical services that my therapist provides. This estimate is based avg. cost if a client is paying out of pocket.

Initial Intake at $190 (what is billed to insurance and what is her cash pay rate) 90791

Then there could be an estimate of 12- 24 sessions depending on the severity of the issue for which you are seeking treatment. The rate for these sessions are billed at $150 per

session (90837).

The total Good Faith Estimate based on Significant Depression or Anxiety Disorders is $1980 to $3780. **This concludes the Good Faith example of fee assessments**

Sliding Scale Fees:

Please fill in if you have arranged a SFS amount with your therapist.

I have been informed that I qualify for Sliding Scale Fee and have been given a rate of $_____. (*initial_____).*

Insurance Usage:

I understand that if I want to use my insurance, even though I have submitted insurance information for verification from Alma or to Kimberly Kline, I am aware that I am being asked to call the number on the back of my insurance card and to confirm that Kimberly is in network with my Insurance carrier. I agree to take on that responsibility. I am aware that my therapist may have multiple Tax Ids credentialed with insurance companies and I will confirm that Alma or she as an individual, is credentialed with my payor. I understand that if I accept Alma's verification statement without checking for myself then I am responsible for any payments that have been represented by Alma.

I agree to check my EOBs from my insurance provider so I can be timely in recognizing and reporting any discrepancy in invoicing.

Required Signature for Insurance X_____I am assigning Insurance payments to be paid to Your Living Well, PLLC or Kimberly Kline, LPCS directly.

I further understand that my therapist may not receive any gifts of any value from me and that she may not engage in any relationships with me, other than a therapist and client one. It is my understanding that my therapist will not engage in any routine touching of my person, (with the exception of biofeedback therapy or auriculotherapy). I am aware that the goal of counseling is to assist me in feeling better and understanding this I agree to enter this relationship in good faith. She/He will not initiate contact with me outside of the office or on social media.

Telehealth Consent:

This is to confirm that the client is aware that there are policies and limitations to telehealth and digital therapy (email or voicemail).

1. CONFIDENTIALITY: The therapist is required to confirm that the video platform is HIPAA compliant. (except during states of Emergency or when the government mandates otherwise. The therapist cannot be held responsible to maintain confidentiality if the client allows others to enter the therapy space. If the client is feeling that confidentiality is being compromised at anytime during the session then it is the responsibility of the client to inform the therapist.

2 .If the connection during a session is discontinued, the **client and the therapist** will continue to make effort to contact each other to close the session. The phone numbers will be provided and agreed to prior to therapy initiation. Failure to comply could lead to termination of services.
3. The emergency policy and confidentiality limitations listed in the consent are still valid and applied to telehealth and digital therapy.
4. The fees for telehealth service are the same as office fees .
5. To maintain confidentiality, there is **absolutely no permission to share written or recorded session information of any kind in any way**. Including, but not limited to any social media, email, or person. If you need to share information, you may request a release of information in writing.
6. Telehealth therapy may be discontinued if there is no ability to maintain an appropriate connection. An alternate plan will be created at that time.

All other standard policies regarding appointments and/or termination remain in place for Telehealth appointments

_____I have received Hipaa Notices and agree to email contact.

Signature _____
Parent/guardian if pt is a minor child_____

DATE:_____

Pt. NAME:_____
Parent Name if minor child_____
Parent DOB: _____

Patient DOB:_____

ADDRESS: _____
PHONE:_____ Allow Texting: Y or N
Email address preferred: _____

Spouse's Name: _____
Spouse Ph # _____
EMERGENCY CONTACT: _____#_____
Relationship _____