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PSYCHOTHERAPIST- PATIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you initial where requested by "x" and sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Except in emergency situations, or where psychotherapy is being administered as the result of a court order, every licensed or unlicensed psychotherapist shall provide the following information in writing to each client during the initial contact.

Tamara A. Kiekhaefer
Degree: Master of Social Work
California State University, San Bernardino, 1999
License: Colorado LCSW, 993066

The Colorado Department of Regulatory Agencies has the general responsibility of regulation the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychotherapists and unlicensed individuals who practice psychotherapy. The agency with the department that has the responsibility specifically for licensed and unlicensed psychotherapists is:

State Grievance Board
1560 Broadway, Suite 1340, Denver, CO 80202
(303) 894-7766

Client rights and information:
x____ You are entitled to receive information from this agency about our methods of therapy, the techniques used, the duration of therapy, if it can be determined.
You can seek a second opinion from another therapist or terminate therapy at any time.
In a professional relationship, sexual intimacy between therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

Privileged Communication:
x____ The information provided by a client during therapy sessions is legally confidential, except as provided in section 12.43.218 CRS and except for certain legal exceptions which will be identified by the license, should any such situations arise during the course of treatment.
Any threats to self or others, and in the case of suspected or reported child abuse, confidentiality regulations do not apply.

Psychological Services:
x____ The practice of psychotherapy is not an exact science and no guarantees will be made to you, as a patient, as to the results of treatment or examinations during the course of treatment. There are benefits and risks involved since therapy often involves discussing unpleasant aspects of your life. At times, you may feel discomfort. However, psychotherapy has many benefits which include developing better relationships, finding solutions to problematic areas, and significant reduction in feelings of distress.

Appointments:
X____ I schedule appointments as 50 minute sessions (one appointment hour of 50 minute duration). Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **24** hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. When possible, I will try to find another time to reschedule the appointment.

Professional Fees:
X____ My hourly fee is $145.00. All payments will be made in full before each session begins. I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than **10** minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $180.00 per hour for preparation and attendance

at any legal proceeding. There will be a retainer fee of $500.00 due prior to any of my services. This will be required in the form of cash, check or cashier's check.

Contacting me:

X____ It is likely you may receive my confidential voice mail if trying to reach me. I check my messages several times a day and will try to get back with you within 24 hours, excluding weekends and holidays. Should I be unavailable for an extended period of time, I will provide the name of another therapist covering for me. If your situation is life threatening, call 911 or your family physician, or go to the nearest emergency room. Telephone calls in excess of 10 minutes will be prorated at my fee of $110 per hour.

X____ In the event you choose to e-mail or text me, you acknowledge that all electronic communication is unsecure. You acknowledge that this may be a form of communication during the therapeutic relationship unless you specifically request otherwise. When therapeutic communication occurs by electronic means, there are potential risks and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. This therapist is aware of the limitations regarding confidential transmission by Internet or electronic media and will take extra care when transmitting or receiving such information.

MINORS and their PARENTS or GUARDIANS (**please read this section in its entirely)**

X____ Minors **under** 15 years of age: Generally, a parent of a minor child under the age of 15 years has the right to access the minor child's patient information. An exception to this may occur because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents. In this case, it may be determined that access would have a detrimental effect on the therapist/ patient relationship with the minor child, or that the minor child's physical safety or psychological well-being may be jeopardized. If a parent or guardian is not actively participating in treatment with the minor child, it is my intent to provide general information about the progress of the minor child's treatment if request.

X___ Minors **over** 15 years of age: In accordance with HIPAA regulation, once the minor child reaches the age of 15 years, any access to his/ her patient information rests solely with the minor child- not the parent or guardian. Please note: If, in my professional opinion, I feel that the minor child may be in danger of self-harm or may be a danger to someone else, it is understood by the minor child signing this document that his/ her right of confidentiality will not apply in these circumstances and I will notify the minor child's parents of my concerns. Before giving the parents any information, I will discuss the matter with the minor child, if possible, and do my best to handle any objections he/ she may have.

Billing and Payments:

X____ You will be expected to pay for each session at the time it is held. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/ her name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

Insurance Reimbursement:

X____ Health insurance policies usually provide some coverage for mental health treatment. It is your responsibility to obtain pre-authorization, when required, from the insurance company PRIOR to the first session. Preauthorization of insurance coverage is not a guarantee of coverage; I can only assist with the benefits and submission of claims, as quotes and payments are at the discretion of your insurance company. Any discrepancy regarding payment for treatment will be the responsibility of you, the Patient. This would occur only if the insurance company does not authorize benefits. Please note: Insurance deductibles and co-pays are payable at the time of service. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, however, you (NOT your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

X____ You should also be aware that your contact with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company's file. Though required to keep your information confidential, I have no control over what they do with it once it is in their hands. By signing the Agreement, you agree that I can provide requested information to your carrier.

By signing the Agreement, you agree that you have received a copy of the service agreement and were made aware of my professional services and business policies of my practice.

_____ _____

Signature of Client Date

_____

Printed name

_____ _____

Tamara A. Kiekhaefer, LCSW Date