Carpenter House, Inc
Kathy White, LMHC, LMFT
4400 Highway 20 East Suite 306 Niceville, FL 32578-5383
Office phone: 850-897-7810 Office cell 850-217-7810 Fax: 850-897-0032
www.carpenterhouse.net

Informed Consent to Treatment and Client Rights Form

Thank you for choosing Carpenter House Inc. and Kathy White, LMHC, LMFT. You may have many questions now that you have chosen to initiate care. This document is intended to inform you of policies, state and federal laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. - Kathy

Your Therapist: Kathy White is a licensed mental health counselor (LMHC) and a licensed marriage and family therapist (LMFT) and is engaged in private practice providing mental health. Services are provided under the business name of Carpenter House Inc.

Relationship: In order to preserve a professional and therapeutic relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship.

Emergencies: Kathy White, LMHC, LMFT does not provide afterhours emergency response. If you are experiencing a psychiatric crisis please contact either 911, or go to your nearest hospital emergency room. Emergencies are urgent issues requiring your immediate action.

Office Policies: For safety reasons children may not be left unattended in the waiting room and must be supervised by an adult at all times. By signing I, the client, acknowledge that business is conducted on the premises and consideration of the business surroundings will be recognized with respect in speech and demeanor.

Termination of Services: In most cases termination of services will occur as a natural result from completing your treatment goals. In the event that payment for services are not completed within one month of provision of service then services may be terminated. Follow up appointments for clients carrying an unpaid balance will not be scheduled. In that event you (the client) will receive notice of intent to terminate, and a list of competent therapists in the area.

Therapist's Incapacity or death: I acknowledge that, in the event that Kathy White, LMHC, LMFT becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. In the event that no other therapist has been assigned, I will if possible select a successor therapist within a reasonable time. If none of these scenarios develops then I understand that my case files will remain in the estate of Kathy White, LMHC, LMFT for the legal period of two years before being destroyed.

Professional Records: The laws and standards of our profession require that I keep Protected Health Information about you in a Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record or a summary report minus information provided from other providers, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you initially review them in my presence. In addition, I may also keep a set of psychotherapy notes that are for my own use and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to you or others with your Clinical Record, except in rare legal circumstances. If I refuse your request for access to your records, you have the right of review, which I will discuss with you upon request. There may be a fee for records and record request can take up to 30 days to be processed by FL law. We will attempt to meet your requests in a timely manner.

Printed Patient Name:_____ DOB:_____ Initials of responsible party:_____

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Appointments: Appointments are made or changed by calling (850) 897-7810. Hours for the business office may vary. A second number - (850) 217-7810 is provided. The number of needed sessions varies. Kathy will be happy to answer any concerns in this regard.

Missed Sessions/Late Cancellation Policy: I, as the client of services, understand that I am responsible to maintain the time that I have scheduled with Kathy White, LMHC, LMFT. Should I need to cancel my appointment, I understand that I am responsible for contacting the office **24 hours before my appointment**. I may leave a message on the business cell at 850-217-7810 or at the office 850-897-7810 to cancel an appointment. I understand that the office is open Monday through Thursday. I will be charged **$50.00** for missing an appointment or failing to cancel my appointment 24 hours prior to my given appointment time. This notification of my intent to miss or cancel my appointment is consistent with the respect that I expect the therapist to give myself when allocating scheduled time. I acknowledge that the missed session/late cancellation fee is NOT reimbursable by insurance. If you are more than 15 minutes late for an appointment you may be asked to reschedule and **$50.00** will be charged.

INITIAL HERE

Initials of responsible party:_____

Payment for Services — Financial Policy: By signing this consent for treatment, I, the client seeking services, understand that I am financially responsible for the cost of treatment. If I have insurance the insurance company will be billed directly as a courtesy to me. In some cases insurance will not completely cover the cost of service. I understand that the insurance is being billed as a courtesy and that I am authorizing payment be made directly to the provider, Kathy White, LMHC, LMFT. If insurance does not completely cover the cost of care I understand that I may be billed for any remaining costs dependent upon the participating status of the provider. I am responsible for paying all co-pays, coinsurances, and/or deductibles at the time of service. Should a denial of services or significant delay in payment occur on the part of the insurance company I acknowledge that I am ultimately responsible for the account balance. I acknowledge that collection actions may be taken should a balance occur after **sixty (60)** days from the date of service. A **cash pay contract** is available if I choose to be seen with no insurance coverage. Forms of payment accepted include cash, check, and money order. Credit card payment may be available but is not a guarantee. I agree that I will have an alternative means of paying my bill readily available. I acknowledge that many types of services are not covered by insurance and may include but not limited to counseling for learning disorders or education.

Returned check policy: I acknowledge that should I choose to pay with a check that I am contracting that such payment may be deposited without any waiting period and that the payment is valid. Should a check be returned for insufficient funds I agree to pay the following fees: The fee is $25.00 for checks valued at $50.00 or less, a fee of $30.00 for checks valued at $50.01 to $300.00 and a fee of $40.00 for checks valued at $300.01+ as dictated by FL law.

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Confidentiality: The content of my treatment will be kept confidential and a written release will be required to disclose information. By law confidentiality is waived when the therapist a) must ensure the protection of anyone threatened with violence, harmful or dangerous actions, b) actual or suspected child or elder abuse, c) when presenting a danger to self d) information necessary for supervision or consultation e) if you are using insurance as the primary form of payment, your insurance company will require information regarding your case: the diagnosis, course of treatment, and prognosis, and in some cases the actual case notes f) If you work for a Federal Agency or are, or will be seeking a security clearance, g) AIDS/HIV infection and possible transmission h) criminal prosecutions i) child custody cases j) a negligence suit brought by the client against the therapist; or filing a complaint with the licensing board k) If you are under 18 years of age, please be aware that the law provides your parents the right to examine your treatment records l) information necessary for third party billing services. While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the HIPAA Notice of Privacy Practices, which was made available to you for more details, and discuss with me any questions or concerns you may have. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care service, and payment for those services and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

I DO **NOT** want a copy of the HIPAA PRIVACY POLICY but acknowledge that I have been given the opportunity to read it and to have a copy provided to me.
Date signed:_____ Patient/Guardian Initials:_____ Staff:_____

OR

I DO want a copy of the HIPAA PRIVACY POLICY
Date Provided:_____ Patient/Guardian Initials:_____ Staff:_____

PLEASE CHOOSE ONE TO INITIAL BASED ON WHETHER YOU WISH TO HAVE A COPY OF HIPAA

DUTY TO WARN: In the event that Kathy White, LMHC, LMFT reasonably believes that I am a danger physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact medical and/or law enforcement. In addition I ask that the following persons be notified: Name: _____Telephone: _____
Failure to sign a duty to warn will keep Kathy White, LMHC, LMFT from rendering care to me.

Patient or legal guardian signature acknowledging duty to warn notice:

_____ SIGN HERE

Date: _____Witness:_____

Printed Patient Name:_____ DOB:_____ Initials of responsible party:_____ INITIAL HERE

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I have read and had the chance to discuss the Informed Consent to Treatment with either Kathy White, LMHC, LMFT or her office staff. I have been given the opportunity to discuss the HIPAA Notice of Privacy Practices and do hereby give full and voluntary consent for the assessment, treatment or services, and to authorize the undersigned therapist to provide such care treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive at any time. By signing this informed consent to treat, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered for me to seek clarification of anything unclear to me.

Patient or Guardian Signature:_____
Patient Name:_____ **DOB:**_____
Date:_____**Witness:**_____

Informed Consent For Minors: This section will only need completed if a minor is being seen.
I, as the parent or guardian of the patient, do hereby grant permission for treatment to be rendered to my child by Kathlyn C. White, MA, LMHC, LMFT, QS. I understand that in the state of Florida a minor is defined as anyone under the age of 18 with the following exceptions: A minor who understands the risks, benefits and proposed alternatives to certain health services may give informed consent, and need not get the consent of a parent or guardian. Minors Who May Consent to Any Medical Care: If a minor fits one of the following categories, she/he may consent to ALL healthcare evaluation and treatment without the consent of a parent or guardian: • A minor who is married or has been married. • A minor age 16 or older who has been legally emancipated by a court. Healthcare personnel may provide confidential outpatient counseling and treatment to minors age 13 and over. Treatment does not include medication.
Patient /guardian Initials:_____
Should my child over the age of 13 choose to seek care without my consent the minor patient may indicate that by signing here:_____

Printed Patient Name:_____ DOB:_____ Initials of responsible party:_____ INITIAL HERE