Carpenter House, Inc
Kathy White, LMHC, LMFT, QS
4400 Highway 20 East, Suite 306 Niceville, FL 32578-5383
Office: 850-897-7810 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. You will be provided with a Professional Disclosure Statement and Policies packet 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.

Emergencies: 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. **You may also contact the National Suicide Prevention hotline at (800) 273-8255.**

Technology-Assisted Counseling (TAC): TAC allows for video-counseling sessions with your therapist. You will be provided with a link for our secure and HIPAA compliant video session. Please know that per best practices and ethical guidelines I can only practice in the State of Florida where I am licensed. That means you must also reside in Florida. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction. During our session, I am in a private location where I am the only person in the room, unless otherwise disclosed. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and to increase sound quality of our sessions. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment. It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include, but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing by email or over the phone.
2. Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. Although every effort is made to prevent confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Missed Sessions/Late Cancellation Policy: An automated text reminder is sent within 72 hours of the scheduled appointed time. Should you need to cancel your appointment, you are responsible for responding to the text or contact the office **24 hours before your scheduled appointment**. The office is open Monday through Thursday, so you may leave a message on the business phone at the office 850- 897-7810 after hours. If you cancel or miss your **first** appointment with Kathy, she may choose not to reschedule. If you cancel two appointments in a row, without directly contacting the office staff, any future appointments will be cancelled. You will be notified by email if your appointments were cancelled. If your future appointments were cancelled, you can contact the office to schedule a new appointment. It is the patient's responsibility to make all **future** appointments. **There is a No Show/Late Cancellation fee of $75.00 that will be charged for missing an appointment or failing to cancel your appointment within 24 hours prior to of your scheduled time.** Missed session/late cancellation fee is NOT reimbursable by insurance. Clients are responsible for full payment of a session if they show up late for the session. This fee is not meant to be a punishment, but is meant to encourage attendance to scheduled sessions and hold you accountable for your time and the time of others.

INITIAL HERE: _____

Printed Patient Name: _____ **DOB**: _____

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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

- in cases of a dispute between counselor and client
- when a client raises the issue of mental condition in legal proceedings
- when a client's condition poses a danger to self or others
- in cases of child abuse or neglect (in addition to mandated reporting laws)
- when the counselor has knowledge that the client is contemplating commission of a crime
- during court ordered psychological evaluations
- for purposes of involuntary hospitalization
- when the counselor has knowledge that a client has been a victim of a crime
- in cases of harm to vulnerable adults

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 is 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, 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 acknowledge I have received a copy of the HIPAA PRIVACY POLICY and have been given the opportunity to read it.

Date Provided: _____ **Patient/Guardian Initials**: _____

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	RELATIONSHIP	TELEPHONE NUMBER

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:

Signature: _____

Date: _____ **Witness:** _____

Printed Patient Name: _____ **DOB**: _____

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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. I acknowledge that 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 Kathy White, LMHC, LMFT. 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 fit 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**: _____