

Kate Dacy LLC

Kate Dacy LLC
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Psychotherapist- Client Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPPA requires that I provide you with a Notice of Private Practices for use and disclosure of PHI for treatment, payment, and health care operations. Please read carefully and we can discuss any questions/clarification that arise. By signing this document, it will 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. The terms of this contract may experience updates/changes and if so, you can obtain a revised copy by contacting me. **Upon completion of your review of the entire document, please sign in the designated area on the last page.**

Psychotherapy Services

“Counseling” and “psychotherapy” (therapy) are often used interchangeably to indicate psychological help to address various kinds of personal and family distress e.g., depression, anxiety, marital conflicts. The goals of therapy often range from the relief of symptoms to significant life change. As we address your concerns, through open communication, to explore challenging aspects of your life, it is normal to initially experience uncomfortable feelings e.g., sadness, guilt, anger, frustration, helplessness. Though there are no guarantees, with continued therapeutic work, clients often describe benefits such as greater calmness, vitality, and confidence, a sense of transformation, better relationships, solutions to specific problems, and fewer feelings of distress. Our first few sessions (2-4) will involve an assessment of your needs. By the end of this time, I will be able to offer you some first impressions of what our work will include and a plan for treatment if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy can involve a large commitment of time, energy and money, so you should

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be very careful about the therapist you select. If you have any questions about our work together, we should discuss them whenever they arise. If necessary, I can provide referrals to other mental health professionals.

Appointments

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. **The time scheduled for your appointment is for you and you alone.** Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (by Friday at 5pm for Monday appointments), or unless we both agree that you were unable to come due to a medical emergency. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. A fee of \$100.00 is charged for no shows or cancellations prior to 24 hours. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time. I will wait 20 minutes for you if you are late for an appointment.

Professional Fees, Cancellations, Billing and Payment

My fee for a standard 50 minute session is \$150.00 and pro-rated accordingly. In addition to weekly appointments, I charge this amount for other professional services you may need. These services include, but are not limited to, report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records and treatment summaries, and the time spent performing any other service you may request of me.

Fee payment is expected at the beginning of each session. Payment schedules for other professional services will be agreed upon when they are requested. I accept cash, check, and credit cards for payment of services.

Should a check be returned to me unpaid, the original unpaid check, along with the service charge, must be paid prior to continuation of services. If it becomes necessary to use collection processes due to lack of payment for services, you will be responsible for fees incurred.

If you become involved in legal proceedings that require my participation, you will be responsible for the cost 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 \$350.00 per hour for preparation and attendance at any legal proceeding including travel time door-to-door. (Insurance will not pay for court activities. Such activities include meeting with an attorney, depositions, letter or reports for the courts, telephone calls and parking fees)

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Confidentiality

The confidentiality of all communication between a client and a psychotherapist is generally protected by law and I, as your therapist, cannot and will not tell anyone else what you have discussed or even that you are in therapy without your written permission. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. The HIPAA Notice Form is attached to this agreement. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. With the exception of certain specific situations described below, you have the right to confidentiality of your therapy. You, on the other hand, may request that information is shared with whomever you choose and you may revoke that permission in writing at any time.

There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collection agency.
5. To the extent necessary for emergency medical care to be rendered.

Finally, there are times when I find it beneficial to consult with colleagues as part of my practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

Confidentiality of e-mail, cell phone, and fax communication

It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited

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and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please let me know at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above- mentioned communication devices. Please do not use e-mail or faxes in emergency situations.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. When I am unavailable, you may leave a message on my confidential voicemail, which I monitor frequently. I will make every effort to return your call the same day but it may take a day or two for non-urgent matters. If you are difficult to reach, please inform me of times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact 911, your family physician or the nearest emergency room. I will make every attempt to inform you of any planned absences and provide you with the name of a colleague to contact in emergencies.

Email

I may request your email address and note you have the right to refuse to divulge email address. Email addresses may be used periodically to check in with clients who have ended therapy suddenly. Counselor may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques.. If you would like to receive any correspondence through email, please write your email address here _____.

If you would like to opt out of email correspondence, please check here _____ .

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 places severe limitations and restrictions on the electronic transfer of client information and records. By signing this agreement, you understand the limitations and risks to confidentiality in the use of email. Please consider who may have access to your email accounts before sending any privileged communication via email.

Social Media AND Telecommunication

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

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Other Rights

If you are unhappy with what is happening in therapy, I hope you'll talk with me so that I can respond to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time.

You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.

You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that I will not have social relationships with clients or with former clients.

Consent to Psychotherapy

Your signature below indicates that you have read this agreement and agree to its terms. Moreover, you agree to hold Kate Dacy PCC free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. Your signature also serves as an acknowledgment that you have been provided with access to the HIPAA Notice Form described above.

Client Name

Date

Client Signature

Date

Parent/Guardian

Date

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