Informed Consent for Treatment

Welcome! In order to better serve you, please review the following. Please acknowledge your understanding and acceptance by providing your initials in the space provided after each individual statement and your signature at the end of the document.

Psychotherapy Guidelines

Psychotherapy

- I offer a range of psychotherapy services for adolescents (13 & older) and adults. The psychotherapy that you receive will consist of meeting with me where I will assist you in setting and working towards goals for desirable changes. There are minimal risks associated with this form of psychotherapy. Potential benefits include positive changes in individual functioning. These may result in decreases in general distress or specific symptoms. _____

Session Times

- Psychotherapy sessions will generally occur once per week for 50 minutes or on a schedule mutually agreeable to you and me. Every effort will be made to begin and end sessions on time. If I am late beginning a session, then when possible, the session will be extended to allow for the full session time. If a patient is late for a session, then the session will usually have to end on time. _____

Fees

- My fee is $120 for a 90-minute individual therapy intake evaluation. My fee is $90 per 50-minute standard therapy session. If a longer appointment is scheduled, or if a standard session runs past 50 minutes, the session will be charged $15 for each additional 15 minutes. Phone consultations are charged at $5 per minute after the first 10 minutes. Full payment of fees are payable at the beginning of each session. Cash, checks, debit / credit cards are accepted. Checks are made payable to Katelyn Chapman. I revisit my fee structure twice a year and will notify you if an adjustment of fee's occurs.

  Upon request, I will provide a copy of services rendered to present to your insurance company for out of network reimbursement purposes. I am an "out-of-network provider" for all insurance companies. This means that your full payment is due at the time of service. Once you submit your claim your insurance company will reimburse you directly for out-of-network benefits. Note that insurance companies require me to assign you a psychiatric diagnosis. You are responsible for contacting your insurance company to inquire about the amount covered for mental health and/or addiction services. It typically takes at least eight weeks for insurance claims to be processed and reimbursed to you. You, not your insurance company, are ultimately responsible for all payment of fees. If you are not filing insurance, there are a limited number of scholarship slots available per session based on needs and availability.

  You are personally accountable for ensuring that your fee is paid on time. If for any reason an account balance has been accrued, the balance is due within 10 days of the statement/invoice date. If for some reason payment is not received for as many as two sessions, then further services will be discontinued until all unpaid charges are paid. To avoid this, it is strongly suggested you complete the debit / credit card document so that I can bill your debit / credit card, if need be. _____

Cancellations/Missed Appointments

- An appointment represents time reserved personally for you. Cancellation and/or rescheduling of appointments must be done 24 hours in advance or the fee will be charged for the session. Cancellations must be made via phone call or voice mail, not through email correspondence. Insurance cannot be billed for a missed or late appointment, so you will be responsible for the entire charge of the reserved time. The reason this policy is in place is to give me an opportunity to fill the slot you have reserved/cancelled with another patient who is available and in need of an appointment. _____

Waiver of Liability and Confidentiality

I am aware that all statements I shall make are of a confidential nature, including all written information, and ethically may not be disclosed without my written consent with the following exceptions that will result in confidentiality being waived:

1. A therapist working with an adult, adolescent, or a child is required by law to disclose to the appropriate person, agency and, or civil authority any harm that a person may attempt or desire to do to one's self or to others, and is required to disclose any reasonable suspicion of physical or sexual abuse being done or having been done to a minor child or a dependent person.
2. Katelyn Chapman reserves the right to consult with professionals regarding your treatment. To insure the highest quality of service to you and for Katelyn Chapman's supervision and professional development, Katelyn Chapman meets regularly with David Williams, RN MSN LCAS CSI MAC, along with a consultation team of therapists. The consultation team may be privy to information obtained during your psychotherapy sessions, yet the team also upholds all of the aforementioned confidentiality agreements in strict professional confidence.
3. Although the courts usually hold psychotherapy records as privileged, therapists are professionally bound to comply with subpoenas given by a court of law.
4. I acknowledge that in the event that Katelyn Chapman becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. I give my consent to allow another licensed mental health professional selected by Katelyn Chapman to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.
5. ***In the event that Katelyn Chapman reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for her to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:***

Names and phone numbers to call incase of emergency:

_____ _____

By providing my signature, I acknowledge that I have read, understood, and have agreed to the Psychotherapy Guidelines and the Waiver of Liability and Confidentiality, that I am responsible for all fees incurred, and that I accept the stated conditions and limits of confidentiality.

_____ _____
Your Printed Name (patient) Date

_____ _____
Your Signature (patient) Date

_____ _____
Therapist Signature (Katelyn Chapman, MA, LCASA) Date

Debit / Credit Card

As a courtesy to my patients, I am able to process your credit or debit card for session fees and missed / late / cancelled appointments. Please read the information below, fill out the necessary information, and sign at the bottom of this page if you agree to the credit and debit card policy listed below.

Your debit or credit card can be billed for the following purposes:

1. Full payment of session or phone conversations exceeding 10 minutes as stated above (usually billed within 24 hours of service).
2. Full payment of missed / late / cancelled session. Katelyn Chapman reserves the right to charge the debit or credit card listed below for any late / missed / cancelled sessions (usually billed within 24 hours of service).

Card Info:

Type of Card:
Card #:
Expiration Date:
Security Code:
Full name on Card:
Billing Address:

I have read the above information in its entirety and acknowledge my understanding of the content. I authorize Katelyn Chapman to bill my card for the reasons listed above.

_____ _____

Your Printed Name (patient) Date

_____ _____

Your Signature (patient) Date

Notice of Privacy Practices

Effective January 18, 2017

My practice follows professional standards and laws to protect your privacy. Federal laws require me to provide you with a notice of my privacy practices. This notice ascribes how I may use medical information about you and how you can obtain access to this information. Please review it carefully and ask me if you have any questions. If I change or revise this notice, I am required by law to inform you of any such change.

By law, I am required to:

- Make sure medical information that identifies you is kept private
- Give you notice of our legal duties and privacy practices with respect to your medical information
- Explain how, when, and why I use and/or disclose this information
- Follow the terms of such notice

I will ask for your written permission to share with or obtain information from others about you. However, by law, your therapist, physician, and their administrative support may use and disclose information regarding your medical information without your authorization for the purpose of providing health care services to you, pay your health care bills, support the operation of the practice, and any other use required by law.

For treatment: I may use information about you to coordinate my services with others who are involved in your health care for referral purposes.

For payment: I may use and disclose medical information about you so that the treatment services I render may be billed to and payments collected from you, an insurance company, or other third party. If payment is not received within 3 months of services rendered, a collection agency will be contacted. For health care operations: I may need to use or disclose information for my practice activities.

As required by law: I may disclose medical information about you when required to do so by federal, state, or local law.

To avert a serious threat to health or safety: I may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public, or another person including situations related to abuse, neglect, or domestic violence. I am required to take steps to prevent you from harming yourself or another person.

Workers compensation: I may release medical information about you for workers compensation and similar programs.

Lawsuits and disputes: If you are involved in a lawsuit or dispute, I may disclose medical information about you in response to a subpoena, discovery request, or other legal process.

Psychotherapy notes: Notes have special protection under law. I will not release my notes without your permission, except as required by law.

Your Rights About Your Private Identifiable Information

Request Restrictions: You may request further restrictions on our uses and disclosures of your information. I may not be able to agree to all requested restrictions.

Different ways to communicate: Typically I will communicate by mailing or phoning your residence or cell phone. Use of email communication is limited.

Right to see and copy information: You may see and receive copies of your information maintained in your designated record. You must submit your request in writing. There are situations in which your request may be denied.

Right to request amendment of your information: You may request that information about you be amended or changed. You must submit your request in writing. I may deny your request if I did not create the information or if I believe the information is correct. Denials will be written and will describe your rights for further review.

Listing of previous disclosures: You may request a list of certain disclosures of your information for up to the last six years. You must submit your request in writing. This list does not include disclosures related to your treatment, payments, or my practice operations, or those disclosures required by law.

Copy of this notice: You may request a copy of this notice at any time.

If you believe I have violated your privacy rights or you want to complain to me about my privacy practices, you may give me written notice and/or you may file a complaint with the U.S. Department of Health and Human Services at the following address:

The Honorable Tommy Thompson
Secretary of Health & Human Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

Should you file a complaint, action will not be taken against you nor will services to you be changed.

Use and Disclosure of Therapy Notes

The information in this policy applies to all of Katelyn Chapman's staff and other contractors granted access to protected health information.

Therapy Notes: Summary of information such as current state of the patient, diagnoses, problems, symptoms, themes of therapy sessions, and other information needed for treatment or payment shall be placed in the patient's designated record. Therapy notes are kept separate from the rest of the patient's designated record. Therapy notes are defined as documentation that captures the provider's impressions about the patient, couple, or family containing details or the conversation to be inappropriate for the designated record and are used by the therapist for future
sessions. The provider who is documenting or analyzing the contents of the conversation during a private therapy session or a group, joint, or family session can record the therapy notes in any medium.

Release/Authorization of Therapy Notes: Katelyn Chapman may not release therapy notes, except in specific situations or if required by law. The patient does not have the right to inspect or obtain a copy of the therapy notes.

A patient may not request a review of the provider's denial of access to therapy notes; however, the patient may be provided access to a summary of treatment/therapy. The authorization for therapy notes may not be combined with an authorization for any other protected health information. Authorization for the disclosure of therapy notes is not required in the following circumstances:

- For use of the provider for treatment
- For use in supervision or training for supervisees to learn to practice therapy and counseling
- To defend a legal action brought by the patient
- For the purposes of the Department of Health and Human Services in determining compliance with the privacy rule (HIPPA-Health Insurance Portability and Accounting Act)

- As otherwise required by law
- By an oversight agency for the lawful purpose related to oversight of the therapist
- To law enforcement in instances of permissible disclosure related to a serious or imminent threat to the health and safety of a person or the public
- To a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death, or other duties authorized by law

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Receipt and Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received and have been given an opportunity to read Katelyn Chapman's Notice of Privacy Practices. I understand that if I have any questions regarding this Notice of my privacy rights, I can contact Katelyn Chapman. I understand that I may revoke, in writing, this authorization at any time except to the extent that action has already been taken in accord with it.

_____ _____

Your Printed Name (patient) Date

_____ _____

Your Signature (patient) Date

_____ _____

Therapist Signature (Katelyn Chapman, MA, LCASA) Date

Authorization to Release and/or Obtain Information

From: Katelyn Chapman, MA, LCASA
1803 Chapel Hill Rd., Suite B
Durham, NC 27707
(919) 960-1424

To: (e.g. current psychiatrist, previous therapist)

_____
_____
_____

Concerning
Patient: _____
Date of birth: _____
SS #: _____

Purpose of sharing information: *Continuity of Care and/or* _____

I hereby authorize Katelyn Chapman, MA, LCASA,

- ❑ to obtain from you the above information regarding myself or my dependent, above named.
- ❑ to release to you the above information regarding myself or my dependent, above named.

This release is limited to the parties noted in this document and is authorized with the constraints of confidentiality applicable to all parties. The exception being that my therapist may consult with another professional regarding my treatment, in which case that professional would also be under the restraints of confidentiality.

This authorization is valid for 12 months from the date of signing and is subject to revocation, in writing, at any time.

Method for Contact:

- ❑ Please expect a phone call
- ❑ Please mail information to the above address

_____ _____
Printed Name of Patient/Guardian Date

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Therapist (Katelyn Chapman, MA, LCASA) Date