AMBER HARRIS, MS, LCMFT

Patient Name_____DOB_____Date_____

INFORMATION AND AGREEMENT FOR SERVICES

Your therapist's practice was founded to promote the healing and growth of individuals, marriages and families through clinically proven methods of therapy and education. The following information is provided to avoid misunderstandings and to facilitate a therapeutic relationship with your therapist.

YOUR THERAPIST

Your therapist, Amber Harris, holds a Master's Degree in Family Therapy and is clinically licensed in the state of Kansas. She is committed to uphold the ethics of the counseling profession, which demand strict confidentiality and the highest regard for the value of your time, finances and person.

CONTACT YOUR THERAPIST

Your therapist's telephone number is 316-789-8511. If your therapist is not immediately available, you may leave a message on your therapist's confidential voicemail.

CRISIS EMERGNENCY SERVICES

If you have a life threatening emergency after office hours, you may call 316-619-5447 for assistance. If you are in immediate danger, get to a safe place and call 911.

APPOINTMENTS

Daytime and evening appointments are available, according to your therapist's schedule. Appointments are scheduled for 55 to 60 minutes. Small children brought with you to therapy must be included in the session and not left unsupervised in the waiting room.

MISSED APPOINTMENTS

To be effective, counseling and psychotherapy need to take place on a regular basis. The best results occur when appointments are scheduled and attended regularly. Because each appointment is reserved specifically for you, it is necessary for you to cancel no less than 24 hours in advance. There is a $40.00 no-show fee for sessions not canceled prior to the scheduled date and time.

CONFIDENTIALITY

Federal and state laws and regulations protect the confidentiality of mental health information and records. Violation of such is a crime. By signing this agreement you are authorizing your therapist to use and disclose your mental health information for the purposes of treatment, payment, and health care operations as outlined in the copy of the Privacy Practices, which has been provided to you. You have a right to revoke this consent if you do so in writing, except to the extent that your therapist has already disclosed the information in reliance with this consent.

If you communicate with your therapist by email and/or cell phone, please be aware that these tools can be accessed by unauthorized people and may compromise the privacy and confidentiality of such communication. **To authorize email/cell phone communication initial here**_____

PATIENT RIGHTS & RESPONSIBILITIES

- You have the right to be fully informed about fees for therapy and the methods of payment available.
- You have the right to ask questions about your therapy. If you request, your therapist will explain her therapy approach and methods used, as well her Code of Ethics.
- You have the right to specify and negotiate therapy goals.
- You have the right to end therapy at any time without moral, legal or financial obligations, other than

those already created. If a referral to another therapist is desired your therapist can assist you with that.
- You have the responsibility to provide your therapist with accurate information as to how she might best help you and to keep your therapist advised of your needs.

CONSENT FOR TREATMENT OF A MINOR CHILD

Therapy can be a very important resource for a child. Establishing a therapeutic relationship outside of the home can provide an emotionally neutral setting in which a child can explore feelings and experiences that are impacting his/her life. It is the therapist's primary responsibility to respond to your child's emotional needs. To do that, you are requested to give permission for the following:

- For the therapist to meet with your child in therapy with or without your presence, whichever the therapist determines the most beneficial.
- For the therapist to reveal or withhold information that in her judgment is necessary to best help and protect your child.

The therapist is legally obligated to report to the proper authorities concerns she may have regarding the safety of your child (neglect, physical, emotional or sexual abuse). When possible, the therapist will advise you regarding her concerns prior to a report being made.

CUSTODY EVALUATIONS / TESTIFYING IN COURT

Marriage and Family Therapists serving in a clinical role must comply with the AAMFT Code of Ethics Principle 3.14, which states: "To avoid a conflict of interest, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence, or visitation of the minor. The marriage and family therapist who treats the minor may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective. For example if you choose to subpoena your therapist regarding custody arrangements your therapist will only be able to respond with "I have not conducted the evaluation necessary to provide an opinion on this issue, so I cannot answer the question." This is due to the above stated AAMFT Code of Ethics.

_____**Please initial stating that you agree not to subpoena your therapist due to custody or visitation actions.**

This authorization may be revoked at any time, however prior to revocation, therapy will be conducted as above. Unless revoked, this authorization will be in force for a year following the cessation of treatment.

Acknowledgements (please initial below)

____I have received a copy of the Notice of Privacy Practices
____if requested, I have received a copy of this Information and Agreement for Services
____I am authorizing my therapist to consult with her colleagues as needed (using nonspecific information)
____I/we agree to the provisions for treatment of a minor _____not applicable
____I agree that any information that was not clear to me regarding my agreement for therapy and financial responsibility have been explained to my satisfaction.

Patient Signature_____**Parent/Guardian**_____

I have presented the issues above to my client(s). My observations of his/her behavior(s) and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent.

Therapist_____Date_____