**Informed Consent and Therapeutic Contract**

The Rock Counseling Center is associated with SouthRock Christian Church – Derby Kansas. The therapists at The Rock Counseling Center are Licensed Clinical Marriage and Family Therapists, licensed in the State of Kansas. Each therapist practices under state guidelines and the Code of Ethics set forth by the American Association of Marriage and Family Therapists. The client is entitled to a copy of the ethics at any time.

**Office Hours**

Business office hours are 9:00 am- 5:00pm Monday through Friday. Appointments for therapy are set by the therapist.

**Appointments**

Appointments are scheduled by each therapist by availability. The sessions will last 45-50 minutes, which is a clinical hour. If you must cancel or change an appointment, we ask that you give a 24 hour notice. All calls are appreciated! We ask that you are on time for your appointments. If you are late to an appointment, the appointment will end at the scheduled time and the fee does not change. If the therapist is late, the time will be made up at the end of your session and you will be guaranteed 45-50 minutes sessions.

**Confidentiality**

In accordance with state regulation and/or professional ethics, specific circumstances require the therapist to break confidentiality and report information obtained as a result of the therapeutic process. Those circumstances exist when: a) therapist believes a client to be a danger to self or others; b) therapist believes that a child, elderly or disabled person may be subject to abuse or neglect; and c)when a court order exists that compels information regarding the therapeutic process be provided.

**Patients Rights, Responsibilities, Risks and Benefits**

As with any type of treatment, there are risks and benefits of therapy. If you are interested in what those are, please let the therapist know and a copy of those risks and benefits will be given to you. Also there are certain rights and responsibilities for the client which are also available upon request.

**Primary Care Physician or Psychiatrist**

By Kansas law, the therapist is required to contact your primary care physician or psychiatrist to coordinate/discuss any medications that might contribute to or disrupt treatment. You may sign a waiver if you do not want the therapist to contact your PCP or Psychiatrist.

**Professional Fees**

Traditional Fee: \*Initial Session: $180 Sessions Following Initial: $160

Discount Option: \*Initial Session: $100 Sessions Following Initial: $100

\*Initial fee is higher because of the extra paperwork and time involved in the process of beginning sessions with client.

All copays and other payments are due at the time of service. If the payment cannot be made at the time of the scheduled appointment, the therapist reserves the right to cancel and reschedule the appointment. The payments can be made in the form of cash, checks, or credit card payments. There are additional fees for the therapist performing services on your behalf such as, but not limited to, hospital visits, consultations, home visits, research, preparation of letters, reports or other material, preparing /responding to a subpoena, deposition or court hearing. Below is a description of each Fee Option.

*Missed Appointment Fee: $40 due at time of next scheduled appointment.*

**□ Traditional Fee Option(Client has opted to use insurance to cover cost of treatment)**

With this option, the client has agreed that The Rock Counseling Center or Kimberly Davis, MS, LCMFT will be filing a claim with the insurance company. All insurance information needs to be given to Mrs. Davis prior to the first session and a copy of the insurance card will be kept for future billing purposes. **Client is responsible for paying the required copay and/or deductible at the time of service.** If copay is not paid at the time of service, the session may be canceled and rescheduled. By choosing this option as payment, the client agrees to the following:

1. I am giving The Rock Counseling Center and Kimberly Davis, MS, LCMFT permission to release any necessary information obtained during the intake process or following sessions for the purpose of submitting claims and/or securing timely payment from the insurance provider and/or third parties, including government-sponsored programs such as Medicaid (Regulations apply).

2. I understand that I am responsible for all charges, regardless of insurance coverage.The client services include individual and family therapy. I am responsible for the copay at the time of service.

**□ Discount Fee Option (Client has opted to self pay at Time of Service)**

With this option, the client has agreed to pay for therapeutic services without the use of insurance. To use this option, the client must pay at the time of the appointment and waives the right to have The Rock Counseling Center or Kimberly Davis, MS, LCMFT file insurance claims on your behalf. Because insurance claim processing is time consuming and a major expense, we offer this option as a way to eliminate the need to send statements, track pending claims and actually file the claim. Again, the payment is due at the time of service and can be paid with cash, check or credit card.

**Coordination of Benefits**

Do you or your family members have insurance other than what you have already disclosed? Yes No (Circle one)

**Technology**

Email and cell phones have a risk with confidentiality issues because of security issues. At The Rock, every precaution will be utilized to protect your information by using secure products. If you agree to allow the therapist to communicate by email or cell phone please initial here

**Acknowledgements**

□ I understand I can receive a copy of the Notice of Privacy Policy.

□ I agree that the information that has been presented is clear and understandable. Any questions have been explained fully and to my satisfaction. I understand my agreement for therapeutic services and financial responsibilities.

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| --- | --- |
| Client Signature Date | Client Signature Date |
| Client Signature Date | Client Signature Date |
| Client Signature Date | Client Signature Date |

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| --- | --- |
| Therapist | Date |