



Therapy Agreement, Policies & Consent

PART 1: CONFIDENTIALITY:

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. (Florida statute 39.201). If you reveal information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect (Florida statute 415.1034). If you reveal information relative to vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself – I am permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information. (Florida statute 491.0147 & Chapter 394).
- **Harm to Others**: Threats regarding harm to another person (Florida statute 491.0147). If you threaten bodily harm or death to another person, I am permitted by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you an email or letter (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy**: If you are in therapy ordered by the court, and the court requests records or documentation of your participation in services, the information/documentation that will be discussed/sent on your behalf will be discussed with you prior to information being sent to the court.
- **Written Request**: Your specific request, in writing, to disclose information regarding your psychotherapy to you or to a third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session (“process notes”), I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records, unless the third party is a treating psychotherapist (Florida Statute 456.057 & HIPAA Privacy Rule). If therapy sessions involve more than 1 party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation i.e. your signature on the “Therapy Agreements and Consent” that covers the cancellation policy to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.
- **Couples Counseling & “No Secret” Policy**: When working with couples, all laws of confidentiality exist. I request that no separate party of the couple attempt to triangulate me into keeping a “secret” that is detrimental to the goal of therapy for the couple. If one party of the couple requests that I keep a “secret” in confidence, I may choose to end the therapy and give you referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public**: My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.
- **Social Media**: If you choose to connect with me on any of my professional (not personal) social media outlets such as Facebook, LinkedIn, or Instagram, you do so at your own risk. I will do my best to protect your identity. However, if you choose to comment on my pages or posts, you do so at your own risk and I cannot be held liable if someone identifies you as a client.

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- **Electronic Communication:** Email offers an easy and convenient way for therapist and client to communicate, but can also introduce unique challenges into the therapist–client relationship. Below are some guidelines for contacting me using e-mail. **Do not use e-mail for emergencies.** If it's an emergency, consult with an emergency room. E-mail is not a substitute for seeing me. If you think that you might need to be seen, please call and book an appointment. E-mails should not be used to communicate sensitive medical or mental health information. **E-mail is not confidential.** Be aware that if you send e-mails from your work, your employer has the legal right to read your e-mail. E-mail is a part of your record. Further, texting also introduces some of the same challenges. Like e-mail, it is not a substitute for seeing me or making an appointment. **Texting is not confidential.** Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over a text. Further, I cannot know the person who is texting is actually you, rather than another person who has possession of your phone.

PART II: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to help provide you with the most effective therapeutic services. I can make no guarantees as to the ultimate outcome of therapy.

EXPECTATIONS: Work outside of the counseling sessions is an essential aspect of change. I may assign tasks between sessions related to your goals. My commitment is to work as efficiently as possible, but at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals and periodically review your progress toward them.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and may involve experiencing discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work together for a desirable outcome; however, there is a possibility that the goals of therapy will not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

STRUCTURE OF THERAPY:

- **Intake Phase** – During this phase, we will discuss the process, structure, policies and procedures of therapy. This occurs during the 1st session. We will need to spend some time (usually brief) exploring your experiences both surrounding the presenting complaint(s) and outside the realm of your complaint(s).
- **Assessment Phase** – An initial evaluation may last from 2-4 sessions. During the assessment phase, I am getting to know and understand you, your worldview, strengths, concerns, needs, family and relationship dynamics, etc. During this phase I am gathering a lot of information. During this phase it may not feel like we are moving forward quickly, but it is imperative for me to gather this information to assist you the best I can. During this time, we both decide if I am the best person to provide therapeutic services for your specific needs. If you or I determine that I am not the best person to address your needs and treatment plan, then referrals will be made for a more appropriate treatment provider.
- **Goal Development/Treatment Planning** – After we have explored and developed sufficient background to proceed, we will collaboratively identify specific goals for therapy. Therapy is best concluded through mutual agreement among the participants, including myself as therapist, and will be directly tied to sufficient progress toward and/or the achievement of the goals we set together. If you are court ordered, we encompass both what is important to you and what the court is requiring of you into the goal. If you are court ordered, it is important to

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provide copies of documents from the court that states what needs to be addressed during our counseling sessions. After the goal is completed we will both sign the goal and you will receive a copy.

- **Intervention Phase** – This occurs anywhere from session 2 until graduation/discharge/termination. This phase requires effort both in session and completing any agreed upon assignments outside of session. You will maximize therapy by implementing solutions discussed during session. During this phase we will review your progress and make any adjustments to your goals as needed. If at any time you have questions about what I am attempting to do or where we are headed, please do not hesitate to ask.
- **Graduation/Discharge/Termination** – As you progress and get close to completing your goals we will collectively discuss your progress, make a transition plan and decide on the date of graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine from session to session how much longer therapy is recommended.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you agreed upon. You agree to adhere to the following policy: *If you are prevented from keeping a scheduled appointment, you MUST notify me 24 hours in advance. If I do not receive a 24-hour advance notice, you will be responsible for paying the full fee for the session you missed.* Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I will, from time to time, take time off for vacation, to attend seminars, and/or become ill. I will attempt to give you adequate notice in advance and will arrange coverage for any emergencies by a colleague. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague contact you to cancel or reschedule an appointment.

FEES: My fee for each session is \$200.00. Payment is due at the time of the session in the form of exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus \$25.00 for any returned check), or credit/debit card. In the event that you miss your scheduled appointment time or cancel less than 24 hours, your credit card or debit card on file will be automatically charged. By signing this document, you agree to such cancellation and returned check fees.

I reserve the right to terminate our counseling relationship if more than four sessions are missed without proper notification.

I charge my hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed to your credit/debit card on file.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if I get called into court by you or your attorney, which I strongly suggest not being involved in court in order to protect your confidentiality, you will be charged \$200.00/hour which will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc. A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to Kuhl Psychological Services or needs to be returned to you after the appearance will be due/returned within 2 calendar weeks.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records they will be dispensed at \$1.00 per page. Payment for your medical records will be due prior or upon receipt of them and can be picked up at our office please allow at least 2 weeks to prepare your records. You will also need to sign a release for medical records to be dispensed to either you or designated party, and I reserve the right to provide a summary of process notes, in lieu of the actual notes, as described above.

PHONE CONTACTS AND EMERGENCIES: Office hours are by appointment only. Dr. Kuhl has availability Monday through Sundays, depending on the services needed. If you need to contact me for any reason please call (954) 256-0800, leave a voicemail, and I will get back to you within 24 hours. In emergency situations, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or simply dial 911 if either you or

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someone else is in danger of being harmed. For residents living in Broward Florida you can call, First Call for Help of Broward 954-537-0211, Henderson Mobile Crisis Unit for adults at 954-463-0911 or for children at 954 677-3113 ext 3, or simply dial 911 if either you or someone else is in danger of being harmed.

PART III: REASONS WHY I DON'T ACCEPT INSURANCE

I would like to share with you my position on why I don't accept health insurance.

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you or I must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list (who offer truncated and reduced-fee services in order to be placed on this list). Reimbursement is sharply reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** When visits are authorized, usually only a few sessions are granted at a time. When these sessions are finished, your therapist must justify the need for continued service causing a delay in treatment. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you do not feel you have achieved your therapeutic goals. Your insurance company may request or require additional clinical information that is confidential in order to approve or justify a continuation of services. The information they may request may include: treatment plans, progress notes, and at times the entire medical record is requested. I cannot assure or guarantee your confidentiality when an insurance company requires this information. Even if the therapist justifies the need for ongoing services your insurance company may decline services regardless if you think you need continued therapy or not. You are at the mercy of your insurance company to decide your care. You should be aware that some of your personal information might be added to national medical information data banks. For these and other reasons, many therapists openly talk about "the myth of confidentiality" whenever insurance companies become part of the therapeutic process.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require the therapist to give you a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") in order to get reimbursed. Most therapists do not inform their clients of this process and place a mental health disorder diagnosis on their record without consulting or informing them of this process. Psychiatric diagnoses may come back to negatively impact you in the following ways:
 1. Denial of insurance when applying for disability or life insurance;
 2. Company (mis)control of information when claims are processed;
 3. Loss of confidentiality due to the increased number of persons handling claims;
 4. Loss of employment and/or repercussions of a diagnosis in situations that require revealing that you have a mental health disorder diagnosis. This includes but is not limited to applying for job applications, applying for financial aid, and concealed weapons permits.

It is also important to note that some psychiatric diagnoses are not even eligible for reimbursement. This is often true for marriage/couples and family therapy as well.

Why I Don't Take Insurance: These involve enhanced quality of care and other resulting advantages such as:

1. You determine and are in control of your care. You may see whomever you wish, whenever you wish, and for as long as you feel is necessary. You and your therapist make treatment decisions jointly – not someone you have never met.
2. Increased privacy and confidentiality. I hope to create a sense of safety within therapy so you can talk freely about what concerns you most, within your informed consent and federal and state laws.

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3. Not carrying a mental health disorder diagnosis on your medical record. You may wish to consult with me on many non-psychiatric issues, such as finding skills to cope with life changes, learning more effective communication techniques for your relationships, or gaining personal insight and developing new, healthy skills.
4. Utilizing your therapy for things that are important to you - you may want your therapy to revolve around things that are important to you such as career counseling, finding your ideal mate, improving communication, gaining personal insights, or developing ways to have a healthier lifestyle. Insurance will not reimburse for these types of sessions.

After reading my position on why I don't accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

PART IV: EMERGENCY CONTACT:

It is necessary that Dr. Kuhl at Kuhl Psychological Services, Inc. has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone
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Number(s) Please check here that you agree and sign below.

I agree to allow Dr. Kuhl at Kuhl Psychological Services to contact my emergency contact on my behalf in the case of emergency

Signature	Date
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PART V: CONSENT

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Dr. Kuhl**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Dr. Kuhl** to provide counseling services that are considered necessary and advisable.

2. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Dr. Kuhl to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Dr. Kuhl prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Minor Child	DOB	Date

** Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. If you initially received this paperwork through email it will be considered that you have an electronic copy. If you did not receive this through email you can be provided a copy per your request.*

Printed Name	Signature	Date

Witness – Dr. Heather Kuhl, PsyD, LMFT

Date

CLIENT COPY

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Dr. Kuhl**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Dr. Kuhl** to provide counseling services that are considered necessary and advisable.

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Printed Name of Minor Child	DOB	Date

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Printed Name	Signature	Date

Witness – Dr. Heather Kuhl, PsyD, LMFT *Date*