Kimberly Wildes, DrPH, MA, LPC
Individual, Couple, and Family Counseling

1458 Campbell Rd., Ste. 250A
Houston, TX 77055
Ph: 281-896-1194; FAX: 713-467-6532
info@kimberlycounseling.com; www.kimberlycounseling.com

Notice of Policies

Thank you for choosing me for your psychological healthcare. I assure you that I will work with you in a caring and professional manner. Please take a few minutes to read my policies, and do not hesitate to ask any questions that you may have. I want our work together to be a rewarding experience.

OFFICE HOURS
Office hours fluctuate according to my appointments. I will work with you to schedule a mutually agreeable time. I offer sessions weekdays, weekday evenings, and there is limited availability on Saturdays.

SESSIONS
Full individual sessions are 50 minutes and half sessions are 25 minutes. Couples may choose 1 hour and 20 minute sessions, and group sessions are typically 1 hour and 20 minutes long. Other extended sessions are available for those for whom it is necessary. In order to ensure that your time is respected and waiting time does not interrupt your schedule or mine, every effort is made to start and stop on time. Your appointment hour is solely reserved for you, therefore, I make every effort to respect your time and I request that you do the same. If you arrive more than 10 minutes late to an appointment, please be aware that I will not be able to extend your session into the next hour as that hour is already held for someone else.

CANCELLATIONS
I consider a scheduled appointment a commitment between the two of us to work together. I understand that emergencies arise, but please try to maintain your well-being by keeping your appointment and putting your health above daily hassles. If you need to cancel an appointment, please do so at least 24 hours in advance with no charge. Notify me by phone (281-896-1194) and leave a voicemail or email (info@kimberlycounseling.com). This gives me enough time to accommodate other patients who may be waiting for an appointment. **If I do not receive 24 hour notice, you will be charged the full session fee. Also note that insurance does not pay for missed appointments.**

CONTACTING ME
My phone number is 281-896-1194. I do not take phone calls when I am in session, so please leave me a detailed voicemail, and I will return your call. If you do not hear back from me in a reasonable amount of time, please call again, as there is always a chance the call was lost. If you prefer email, you may email me at info@kimberlycounseling.com.

EMERGENCIES
You may reach me at 281-896-1194. Should you be unable to reach me (i.e. you reach my voicemail) and you need to speak to someone right away, you may call the Crisis Hotline at 713-HOTLINE. If you are experiencing a life-threatening emergency, you should immediately go to the nearest emergency hospital, 24 hour clinic, or call 911.

FEES AND PAYMENT
Full payment is due at the time service is rendered. If you are a subscriber of an insurance company for which I am a contracted provider, the fee will be your mental health co-pay. For those patients who belong to an insurance company with whom I am not a contracted provider, I can provide a statement so that you may file it with your insurance company and have them reimburse you directly**. Please be advised that if your insurance company does not uphold your contract for any reason, you will be responsible for 100% of incurred charges.** Also be aware that when you file with insurance, I am required to supply them with information regarding your mental healthcare, which becomes a part of your medical record. It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge on the outstanding balance.

NOTICE OF PATIENT PRIVACY POLICY AND CONFIDENTIALITY
I am required by federal law, due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to keep your protected health information (PHI) private and provide you with a notice regarding your privacy rights and my legal duties and privacy practices. “Protected health information” is information about you, including your demographic, physical, and mental health information, that may identify you and that relates to your healthcare. It is otherwise known as your medical record. There are instances where your

personal information may be used and disclosed to complete your treatment or to complete payment from healthcare companies. A more complete description is available in the handout "Notice of Privacy Practices," which is provided to you.

You have a legal right to confidentiality of what we discuss during our session, the notes that are kept regarding what we discuss, and the fact that you are in sessions at all. I am required by law to keep that information confidential unless you give written authorization, except in certain exceptions: child/dependent or elder abuse or neglect, threatened harm to self or others, mandated court orders, third party insurance information requirements, and requests made by parents for information about minor patients. At times I consult with other mental health professionals regarding my cases. Your information is kept confidential and anonymity is upheld, never disclosing name or personal information.

MEDIATION AND ARBITRATION

If a dispute arises out of or in relation to this agreement to provide psychotherapy or the services themselves, the parties will try in good faith to settle it through mediation conducted by a mediator to be mutually selected by the parties. The parties will share the costs of the mediator equally. Each party will cooperate fully and fairly with the mediator and will attempt to reach a mutually satisfactory compromise to the dispute. If the dispute is not successfully resolved after it is referred to the mediator, it will be arbitrated by an arbitrator to be mutually selected. Judgment on the arbitration award may be entered in any court that has jurisdiction in Harris County, Texas, in accordance with the rules of the American Arbitration Association. Arbitration will be binding. Costs of arbitration, including lawyers' fees, will be allocated by the arbitrator. This agreement includes an opt-out period of 30 days from the time of signature during which time you can decide to rescind agreement to psychotherapy services and mandatory mediation should a dispute arise. You must notify me in writing with a signature and date if you wish to do so.

THE THERAPY PROCESS

I want your experience with psychotherapy to be rewarding and positive. It is important that we both remain honest and open during the process. Psychotherapy has many benefits related to improved well-being, including resolution of the issues which led you to therapy. However, because during therapy you may be discussing negative or upsetting matters, you might actually feel discomfort or an agitation of symptoms as you go through the process. It is important for you to share feelings that you are having. It is also important to realize that just like most treatment, therapy is not absolute and has no guarantee, nor is there a predetermined timeline by which we adhere. Some issues may be resolved in a few sessions, while others may require longer involvement. Therapy typically ends when the therapist and patient agree that goals have been met to a satisfactory level or when progress is no longer made. You are welcome to terminate therapy at any time, but I ask that you give advance notice (a few sessions) so that we can discuss the termination process.

TYPES OF THERAPY

A variety of therapies are available depending on your needs and wishes. At your first visit, you and I will evaluate together what issues you wish to address and the type of therapy that would be most appropriate.

Please check each type of therapy you feel may be appropriate:

Marriage/Couple/Relationship Therapy ____
Individual Counseling ____
Parent Consultation____
Family Therapy____
Neurofeedback ____

I HAVE READ, AGREE WITH, AND FULLY UNDERSTAND THE ABOVE POLICIES:

____

(PRINTED NAME) (SIGNATURE) (DATE)

[If the patient is younger than 18 years old, this must be signed by the parent or legal guardian]

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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Consent for Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Notice of Policies" document and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in the process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I understand there is no guarantee of positive results for psychological healthcare by any provider.

I understand there are other situations where the law may require disclosure of protected health information.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I know that I must call or email to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for the appointment.

I know that if an emergency/life-threatening situation arises, I am responsible for finding emergency treatment by calling 911 and/or seeking treatment at a local emergency hospital or 24-hour clinic.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and provider(s) of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below indicated that I understand and agree with all of these statements.

____ ____________________________

Signature of Patient (or person acting for patient) Date

____ ____________________________

Printed Name Relationship to Patient (if necessary)

I, the therapist, have discussed the issues above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ ____________________________

Signature of Therapist Date

___Copy accepted by patient ___Copy kept by therapist

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Patient Information

Date:	Name:	Birthdate:	Gender:

Social Security #:	Contact Information:	Permission to contact:
Home Address: *Street* *City, State, Zip*	*Home Ph Number* *Cell Ph Number* *Email Address*	*OK to call house? Y/N;leave message? Y/N* *OK to call cell? Y/N; leave message? Y/N* *OK to email? Y/N*

Relationship Status: *Married/Widowed/Domestic Partnership/Single/Committed/Divorced/Never Married*	Do you have children? Y/N; If yes, do they live with you? Y/N If yes, how many? ____ …and what are their ages?

Military Background? Y/N	Documented Disability? Y/N	Brain Injury? Y/N

Last Level of Education Completed: Occupation(State 'Student' if in School):	Employer's Name: Business Address *Street* *City, State, Zip* Work Phone:

Primary Insurance Information Name of Insurance Company: Phone Number to Verify Benefits: Insurance Co. Address: *Street* *City, State, Zip* Insurance ID#: Group#:	Subscriber's Name (if Different from Patient): Relationship to Patient: Subscriber's Birthdate: Employer Name: Work Phone Number:

I hereby authorize payment directly to Kimberly Wildes of all benefits otherwise payable to me for services rendered. I am financially responsible for all charges, whether paid by insurance, and for all services rendered on behalf of my dependents.

Signature and Date:____

Referred by:

How would you rate your current mental health on a scale of 1-10, with 1 = as poor as it could be and 10 = as good as it could be? ___
How would you rate your current physical health on a scale of 1-10, with 1 = as poor as it could be and 10 = as good as it could be? ___
How would you rate your overall well-being on a scale of 1-10, with 1 = as poor as it could be and 10 = as good as it could be? ___

Have you experienced any life changes lately? Y/N Please explain.

What current concerns do you have that are bringing you into see me?

What are your strengths?

What are your weaknesses?

Have you received psychological or psychiatric or counseling care before?☐No ☐Yes→

Provider Name?	Date(s)?	Location?	For what?	With what results?

Have you ever taken medications for psychiatric or emotional problems?☐No ☐Yes→

Provider Name?	Date(s)?	Location?	For what?	Name of Medication(s)	With what results?

Have you ever been abused in any way? ☐No ☐Yes→If you were abused, please indicate the kind of abuse, who abused you, and when it happened.

Do you have a history of suicide attempts, cutting/self-mutilation, or psychiatric hospitalization? ☐No ☐Yes→If yes, please explain:

Are you presently suing anyone or thinking of suing anyone? ☐No ☐Yes→If yes, please explain:

Is your reason for coming to see me related to an accident or injury? ☐No ☐Yes→ If yes, please explain:

Are you required by a court, the police, or a probation/parole officer to have this appointment? ☐No ☐Yes→ If yes, please explain:

Is there anything else that is important for me as your therapist to know about that is not already on these forms? ☐No ☐Yes→ If yes, please explain here or on another sheet of paper: