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 treatment 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. **Please be advised that these items pertain specifically to minors**:

- All records kept in accordance with your child's therapy are subject to court subpoena and may, under some circumstances, be solicited by parties to your divorce, including your attorneys.
- Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters irrelevant to the child's welfare may be kept in confidence. However, these matters may be brought to the attention of others, such as attorneys, therapists, or counselors.
- I am legally obligated to take any concern of child health and safety to the attention of relevant authorities. When possible, should the need arise, I will advise all parties regarding my concerns.

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. 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]

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Consent for Treatment of a Minor

It is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. Sometimes there is disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship. It is my primary responsibility to respond to the child's emotional needs and well-being.

There are many potential benefits to therapy, including but not limited to resolution of the issues that brought the patient into therapy. Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has specifically disclosed to me without the child's consent. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal experimentation, but at other times they may require parental intervention. We must directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I cannot give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $160 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Please sign below that you understand and agree with the information you have read and agree to play an active role in the child's treatment as needed. You are agreeing that you have had a chance to ask any questions you may have.

_____ _____

Signature of Parent/Guardian Date Signature of Parent/Guardian Date

___Copy accepted by Parent ___Copy kept by Therapist

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Minor Patient Information

Date:	Name:	Birthdate:	Gender:

Parent #1 Name: Phone Number: Employer:	Parent #2 Name: Phone Number: Employer:	Guardian's Name: Phone Number: Employer:

Social Security #: Patient Home Address: *Street* *City, State, Zip*	Contact Information: *Home Ph Number* *Cell Ph Number* *Email Address*	Permission to contact: *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*

Was the pregnancy planned? Y/N Is the child adopted? Y/N Were there any birth complications? Y/N Explain.	Who lives with the child? List everyone in the household, relationship, and ages.

Did the child meet milestones? Y/N	Documented Learning Disability or Other? Y/N	Brain Injury? Y/N

School Name: Teacher Name: What grade level is the child in?: How are his/her grades? Poor/fair/average/good/very good How would you describe his/her functioning in school? (gets along w/teachers/students, is shy, outgoing, etc.)	Has the child been expelled or suspended? Y/N Does he/she cut classes? Y/N Is he/she in remedial classes? Y/N Is he/she Gifted and Talented? Y/N How does the school/teacher view the child? (e.g. hyperactive, timid, achiever, procrastinator) May I call the teacher to discuss the child? Y/N If so, please give ph. #:

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:

Please list all residences for the patient.

With Whom	Date(s)?	Location?	Any problems?	Reason for moving?

Has he/she experienced any life changes lately? Y/N Please explain.

What current concerns does he/she have that are bringing you into see me?

Has he/she received psychological or psychiatric or counseling care before?☐No ☐Yes→

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

Has he/she ever taken medications for psychiatric or emotional problems?☐No ☐Yes→

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

Has he/she ever had surgeries or medical procedures?☐No ☐Yes→

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

Please list all nonpsychiatric medical conditions, illnesses, allergies, and associated medications that the patient takes here.

Has he/she been abused in any way? ☐No ☐Yes→If he/she was abused in any way, please indicate the kind of abuse, who abused, and when it happened.

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

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