

Counseling Contract

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816.892.0902

Thank you for selecting me to meet your counseling needs. It is a privilege to serve you and I will do all I can to help with whatever need you have and to provide the highest quality of service. In order to better serve you the following information is being provided. Please examine it carefully. I will be happy to answer any questions regarding items for which you need additional clarification.

Please initial all sections below to which you agree. Any sections not initialed will be discussed prior to treatment.

___ **The Therapy Process:** I use a variety of treatment approaches in order to best help you reach your goals. Change can occur through working on one's thinking, actions, environment, and spiritual condition. Changes can produce varying results and it is necessary to recognize that as one struggles with change, sometimes that struggle may lead one to go through a more difficult valley temporarily. It is very important that therapy continue until you have passed through that valley should it occur.

___ **Confidentiality:** I am dedicated to preserving the confidentiality and privacy of all my clients. However, some state and federal laws require that I disclose information in certain situations. **Please review the following situations in which I must breach confidentiality:**

- **If I suspect child, elderly or disabled person abuse or neglect I am required to report that information to a state agency.**
- **When a client brings charges against the therapist.**
- **When a court orders the therapist's testimony of your records.**
- **I may sometimes talk with another professional about your case in order to get an objective point of view. In those instances your confidentiality will be maintained as no identifying information will be revealed, only the circumstances of your situation. Any professional with whom I consult will also be required by professional ethics to maintain your confidentiality. The exception will be that when I am out of town I may release your information to another therapist who will serve on call should an emergency arise. In this case a little confidential information will be released as is necessary.**
- **When I believe a client is a danger to themselves or others (suicidal or homicidal).**

The laws and ethics of confidentiality are complicated. If you have special or unusual concerns, an attorney is recommended for legal advice.

___ **Treatment of Minors:** Persons under the age of 18 must have permission of the parent or legal guardian to receive therapeutic services. Parents will be involved in treatment as I deem necessary while maintaining the confidentiality of the client except in cases of dangerous drug use, suicidal ideation or running away. In cases of divorce, I will want to involve both parents unless rights have been severed for one or it is otherwise not feasible to do so.

I will not serve as a witness in custody disputes or provide records for such matters. I ask you to agree to accept this policy. If you go to court you will need to receive an evaluation from another professional for those involved. I will provide a summary, if necessary, but not actual records to the court. Charge for this service will be \$80 per hour of preparation must be paid in advance.

If required to attend court proceedings the fee will be \$80 per hour with one hour payable in advance. The charge can be avoided if cancellation is made one week in advance.

___ **Subpoenas:** If your records are requested through subpoena, you will be notified in writing and provided with a copy of the subpoena. You must then provide the therapist with a written objection to the

subpoena or indicate that an objection will be filed with the court (with a copy to the therapist). It is the client's responsibility to file this with the court within the time frame legally allowed.

___ **Appointments:** Counseling sessions are 45-50 minutes and include the time needed to schedule another appointment and make payment. Due to the difficulty of scheduling missed or cancelled appointments, 24 hours notice must be given in order to avoid being charged for the missed session. Bad weather is the exception. If you cancel three appointments, we will discuss issues that may indicate the need for another therapeutic plan.

___ **Fee Policy:** The standard fee is \$90 per session. We do have a sliding scale based on family income for clients in need of assistance, starting at a base of \$50. Ever 10K the fee increases \$10. Additionally, we have a financial hardship policy for clients in need of further assistance. Please ask for an application for financial assistance if you need one. The agreed upon rate for your session is \$_____ per session. Please pay at the beginning of each session and make checks payable to Serenity Life Resource Center. Returned checks are subject to an additional \$25 charge.

Three sessions without payment will cancel future sessions until the account is paid in full.

___ **Insurance:** I do not accept insurance, however, if you belong to a plan that pays for out of network services, documentation will be provided in order for you to request reimbursement.

___ **Clinical Supervision:** While in this stage of licensure, I operate under the clinical supervision of Beth Russell. This supervision involves full disclosure of your file for review. A release of Information will be included in your file.

___ **Consultation:** If you could benefit from a treatment I cannot provide, I will help you get it. You have a right to ask about such other treatments, their risks, and benefits. I will fully discuss the reasons for any additional recommendations I have so you can decide what is best.

___ **Communication:** Sending information through texting and email are not a safe means of communication because there is not proper means for assuring the confidentiality of this information. For the protection of your confidentiality, I will only utilize methods of texting or email with clients in regards to scheduling. Please communicate with me by telephone or in person for any other concern. This will assure that your personal information is kept confidential and is responded to in a therapeutic manner.

___ **Facility hours:** Serenity is not a mental health facility and does not have the staff to maintain 24-hour care. Therapist is available Monday through Friday 9am – 5pm. Therapist will respond within one regular business day. In life threatening emergencies, dial 911. For crisis situations, such as thoughts of harming self or others, you are responsible to utilize resource list, provided at the bottom of this agreement, as well as putting safety measures into place.

___ **No Secrets Policy:** Serenity maintains a “no secrets” policy in couple's and family therapy. This means therapist must disclose all information to all parties (adults) in therapy. This is especially true regarding areas of unfaithfulness.

___ I acknowledge that I have received a copy of the **HIPAA Notice of Privacy Practices**.

It may be beneficial to me to confer with your medical professional with regard to your psychological treatment or to discuss any medical problems for which you are receiving treatment. **Please check one of the following:**

___ You are authorized to contact the following physician whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis.

Physician _____

Phone _____

___ I decline permission to contact my physician with regard to my treatment.

My signature below indicates that I accept the terms and conditions of all initialed policies above concerning my care.

Signature	Date	Signature	Date
Signature	Date	Signature	Date

HELP – FILE COPY

Serenity Life Resource Center is not a mental health center, and do not have a staff to handle 24 hour care. Therefore, we cannot promise that we will be available at all times. Although we are in the office Monday through Friday, we usually do not take phone calls when we are with other clients. You can always leave a message on the answering machine, and we will return your call as soon as we can. Generally, we will return messages daily except on Saturdays, Sundays, and holidays.

If you have a life-threatening emergency, please dial 911. If in crisis (thoughts of harming self or others), If you have a behavioral or emotional crisis and cannot reach me or us immediately by telephone, you and/or your family members should call:

Jackson County Mental Health Services Recommended Responses:

- **If it is a life-threatening emergency: DIAL 911.** Most communities in Jackson County have CIT (Crisis Intervention Teams), police officers specially trained to respond to persons with mental illness in crisis.
- **Missouri’s Access Crisis Intervention number: 1-888-279-2132.** This toll-free number is answered 24-7. Qualified staff is available to talk with you about your crisis and help you determine what assistance is needed. All calls are confidential.
- **Military Veterans:** Contact your Kansas City VA Medical Center: (816) 861-4700.
- **NAMI-KC: (816) 931-0030** The National Alliance on Mental Illness of Greater Kansas City provides information on mental illness has support groups and can make referrals.
- **Hospitals**
 - Lee’s Summit Medical: 2100 Southeast Blue Parkway, Lees Summit, MO 64063 (816) 282-5000
 - Truman Medical Center Lakewood: 7900 Lee's Summit Rd., Kansas City, MO 64139 (816) 404-7000
 - Crittenton Children’s Center: 10918 Elm Avenue, Kansas City, MO 64134-4199 Phone: (816) 765-6600
 - Research Psychiatric Center: 2323 East 63rd Street, Kansas City, MO 64130-3495 Phone: (816) 444-8161
 - Two Rivers Psychiatric Hospital: 5121 Raytown Road , Kansas City, MO 64133-2141 Phone: (816) 382-6800
 - Center for Behavioral Medicine: 1000 East 24th Street, Kansas City, MO 64108-2620 Phone: (816) 512-7000
 - Truman Medical Center: Hospital Hill Mental Health Unit: 1000 East 24th Street, KCMO 64108 (816) 404-5700
 - Kansas City Free Health Clinic: Medical & Mental Health Services: 3515 Broadway Street, KCMO 64111 (816) 753-5144