Limits of Confidentiality Policy

Therapy sessions are considered confidential. NOTED EXCEPTIONS ARE AS FOLLOWS:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, mental health professionals are required to warn the intended victim and report this information to authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempt to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing or recently has abused a child or vulnerable adult, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. If a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients under the age of 18 have the right to access the client's records.

Couples Therapy

At times it may be helpful to meet with both of you individually. I will not keep secrets. I will work with you individually to help you share information to further the therapeutic goals. If one spouse chooses not to share, I will seek permission to share. If permission is not given, I may have to terminate couple therapy.

Insurance

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Clinical Supervision

In accordance with Kansas State Law, I am required to meet with a Registered Clinical Supervisor for professional growth purposes. Individual cases will be shared and advised, but personal identities will not be disclosed.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

SOCIAL MEDIA AND TELECOMMUNICATION Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Court

Children should know their information is protected; feel safe to share. Please do not use them or their information in court. If I am subpoenaed, I am mandated to break confidentiality. Asked to break confidentiality is a betrayal of your child's trust.

Please note that under no circumstances should sessions, phone calls, or any communication be recorded.

Financial Policy

Session Fees:

Payment is due at the time of your appointment.

• $120 for 45 minutes Child/Adolescent Session

• $120 for 50 minutes Individual Therapy Session

• $120 for 50-minute Couple/Family Therapy Session

• $175 for 90 minute Couple/Family Therapy Session

• $150 for written reports to other professionals or billed by the hourly session rate

Cancelation

Cancellations within 24 hours will be billed for the entire cost of the missed appointment.

Court Fee

A non-refundable prepayment of $2,000 will be charged if asked to testify, as I have to take off the entire day from other clients. Plus, $150 will be billed hourly in preparation for court and travel time. A current credit card must be on file.

Phone Calls

Calls over 10 minutes will be charged at the hourly rate. Please call 911 for emergencies.

Insurance Reimbursement

Upon your request, I will provide you with a copy of a receipt, which you can submit to your insurance company for reimbursement. It is your responsibility to verify the specifics of your coverage. You should be aware that most insurance companies require a clinical diagnosis and sometimes-additional information is requested. I have no control over what they do with the information once it is in their hands.

HIPPA

I am required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care OperationsYour Protected Health Information (PHI) is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for Katherine Crabtree to “use” your PHI within her practice group, or “disclose” your PHI to an outside entity for the following purposes:

1 Treatment: providing, coordinating, or managing your health care and other services related to your health care.An example would be when your therapist consults with another health care provider like a physician.

2 Payment: obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

3 Health Care Operations: activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an Authorization Form authorizing that specific disclosure. We would also need to obtain your authorization before releasing your “Psychotherapy Notes”— notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which are

kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI. You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization. We may use or disclose PHI without your consent or authorization in the following circumstances:

1 Child Abuse: If your therapist has reasonable cause to believe that a child has suffered abuse or neglect, she/he is required by law to report it to the proper law enforcement authorities.

2 Adult and Domestic Abuse: If your therapist has reasonable cause to believe that abandonment, abuse, financial exploitation, sexual or physical assault, or neglect of a vulnerable adult has occurred, she/he must immediately report it to the appropriate authorities.

3 Health Oversight: If the State Department of Health subpoenas your therapist as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

4 Judicial or Administrative Proceedings: If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This privilege does not apply when you are being evaluated for a third party or for the court. You will be informed in advance if this is the case.)

5 Serious Threat to Health or Safety: We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

6 Worker’s Compensation: If you file a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

1 Right to Request Restrictions: You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

2 Right to Receive Confidential Communications by Alternative Means at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

3 Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

4 Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

5 Right to an Accounting of Disclosures: You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

V. Therapist's Duties

1 We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

2 We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

Professional Disclosure

Welcome! Kansas State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy, and service policies. It is your right to choose a provider and treatment that is best for your needs. To help you make your choice as we work as a team, here is some basic information about my therapy practice and me. Please read this information carefully and ask me questions.

Approach to Therapy:

Please review my Profile Form, which details useful information regarding my Professional Education and Background, Areas of Specialty, Treatment Philosophy, Licensure, and Certifications.

Discussion of Treatment:

Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of your concern, the treatment plan, therapeutic objectives and view of the possible outcomes of treatment. If you have any unanswered questions during the course of therapy, their possible risks, my expertise, or about the treatment plan, please ask. You also have the right to ask about other treatments that I do not provide. I have an ethical obligation to assist you in obtaining those treatments.

Risks and Benefits:

While most people find therapy to be beneficial, the process of therapy may at times be uncomfortable. New emotions, thoughts and memories may be experienced. Understanding these risks is an important part of consenting to therapy. Therapy also has been shown to have many benefits including a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased ability to manage stress, and resolutions to specific problems.

Telephone and Email Contact:

I will do my best to return your call or email within 24 hours on business days. Please leave your name, phone number you wish to be contacted, and a brief message on my voice mail or a short email message. Phone calls, Zoom, Voice mail and email cannot be guaranteed to be confidential. Phone calls over 10 minutes will be billed as a whole session.

Electronic Communication: You may communicate confirmation and/or cancelation of appointments through email. Although unlikely, it may be possible for others to see information sent through email.

Photographs and Video: On occasion I may ask you if I can photograph work done in a session for comparative work later. These photographs are kept in your file. I also may video tape our sessions for my professional learning and for the safety of children. These videos are erased within a month.

** Please answer Yes or No**

You May Send an Email:

You May Leave Messages on Phone:

You May Send Texts:

I Agree to Photographs of Art Work or Sand Tray:

I Agree to video of session for clinician professional growth:

Consent for Treatment of a Minor

This is an authorization to provide treatment services to my child/adolescent::

Child's Date of Birth and Age:

Treatment Consent:

By signing below, I consent to mental health therapy with Katherine Crabtree LPC, CPT with Heart and Hand Counseling. I also attest that I have read, understood, and agreed to all information on the Profile Form, Professional Disclosure, Financial Policy, Limits of

Confidentiality, and Notice of Privacy Forms.

Client Signature: