Serenity Life Resource Center
Growing Community Together

Counseling Contract

Leeanna Billups M. A. LPC
913-298-1133

Kansas Licensed Professional Counselor (LPC) Lic. # 3117
Under the supervision of Dr. Trisha Brown Ph.D., LCPC

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 per session is $_____ per session. We do have a financial hardship policy for clients in need of 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 _____. This supervision involves full disclosure of your file for review by_____. 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 not utilize the methods of texting or email with clients. Please communicate with me by telephone or in person to assure that your personal information is kept confidential and is responded to in a therapeutic manner.

____ 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 you 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