Kaitlyn Nicholson, MMFT

Counseling Policies

Thank you for the opportunity to work with you. This handout is to provide information helpful in making informed decisions concerning these services. Feel free to ask questions at any time.

About me:
I am a Master of Marital and Family Therapy (MMFT) from Trevecca Nazarene University and am currently seeking licensure in the state of Tennessee. My supervisor is Alicia Lewis, LMFT #1120.

Appointments:
Counseling services are by appointment only. Sessions are 45-90 minutes, and this is known as the "clinical hour". Because the appointment is reserved for you, it is required that you communicate cancellations or rescheduling needs at least 24 hours in advance of your scheduled appointment. **The full rate is charged for missed appointments or cancellations within 24 hours.** Scheduling and cancellations can be communicated by call, text or e-mail.

I have read and understand this policy (please initial): _____

Fees:
My standard fee for a clinical hour (45-50 min) counseling session is $110-$145. I accept cash, check or credit card (Visa, MasterCard, Discover, American Express). This fee also includes my time on your behalf outside our session, including record keeping and preparation. Any fees I may incur for returned checks when processing your payment will be billed back to you, so please be sure you have the necessary funds available when choosing your method of payment. **I require that a credit or debit card be kept in my files in order to bill for any missed appointments (*This card will only be charged with your permission OR in the event that you have not showed for an appointment and have not contacted me to settle your payment*). Please Note: The rate for legal/court related services is double the normal session fee.**

I have read and understand this policy (please initial): _____

Collections for Non-Payment:
In the event that your account is not settled (due to a Non-Sufficient Payment or failing to show up for an appointment and the credit card on file not being activated/having the funds to cover the cost of the session), settlement of payment will be pursued from an external collection agency. If this happens the external agency will receive only the basic information necessary to contact you for payment.

I have read and understand this policy (please initial): _____

Messages:
I do not accept phone calls or check e-mail while I am with clients or outside of my regular business hours. During those times you may leave me a voicemail. It is my policy to return calls, texts or e-mails within 24 hours during the work week (Monday-Friday). In the case of an emergency, please call the crisis hotline at 615-244-7444 or 911, or go to your local hospital emergency room.

I have read and understand this policy (please initial): _____

Use of Email, Phone and Text Messaging:
Electronic communication may only be used for scheduling or questions about appointments. Tone of voice, emotions and other important communication factors are sometimes assumed or misunderstood in electronic communication so it is important to maintain the work in our scheduled session. In the case that a client feels it necessary to send an update/information to me in between sessions, the following shall be adhered to:

1. The client will be billed for the time it takes to read, respond to, print and file all e-mail(s). (Please note, all communication via e-mail or text messaging that goes beyond basic communication regarding scheduling will be printed out and placed in your file and limitations of confidentiality regarding information shared will not apply)

2. If, in the e-mail communication, the client indicates, either outright or by insinuation that they are planning on harming themselves or someone else, the legal mandate of confidentiality shall be applied. The client will be billed for the time it takes to assess the situation, contact the client, develop a safety plan and contact all appropriate emergency contacts, safety and medical personnel in order to ensure the client's safety.

I have read and understand this policy (please initial): _____

Counseling:
Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. They may change employment and begin to feel differently about themselves, and may change other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Infrequently, a patient's distress remains or becomes so high that hospitalization or the use of medication must be considered. I am not a physician and do not prescribe medication; however, at times I may encourage you to consider seeking medical attention. In cases where hospitalization and/or medication may be required, this will be discussed in advance with you and, if necessary, with other responsible parties.

I have read and understand this policy (please initial): _____

Informed Consent:
By signing this document, I authorize and request Kaitlyn Nicholson, MMFT to provide treatment deemed necessary or desirable for my welfare and therapeutic growth. Additionally, I consent to participate in treatment and understand the limits of confidentiality as well as the benefits and risks of counseling. I understand that I can terminate therapy with Kaitlyn at any time.

I have read and understand this policy (please initial): _____

ROOTED RESILIENCE
COUNSELING

Client Rights:
At any time, you may question and/or refuse counseling or diagnostic procedures or ask questions about the process and course of the counseling. Clients are given the respect of the highest level of confidentiality. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions require:

1. That I notify relevant others if I judge that a client has any intention or ability to harm either himself/herself or another individual.
2. That I report any incident of suspected child abuse, neglect, or molestation in order to protect the child or children involved.
3. That in legal cases, my records may be subpoenaed by the court. Confidentiality will be respected in all cases, except as noted above. In those additional cases where in my judgment the maintenance of confidentiality is, in fact, destructive to you, I will inform you of my concern, and you will have the final decision as to whether or not I maintain confidentiality.

When needed, you will be asked to sign a "Consent for Release of Confidential Information" form which will allow me to discuss your evaluation and/or treatment with others (e.g. Physicians, previous counselors, etc.). If you wish, you may also limit the time or release by an expiration date, and/or limit what I have permission to discuss by writing these instructions in the release form.

I have read and understand this policy (please initial): _____

Termination:
Termination of counseling may occur at any time and may be initiated by either the client or the counselor. I request that if a decision to terminate is being made that the final session may be scheduled to explore the reasons for termination. Termination itself can be a constructive and useful process. If any referral is needed or requested, it will be made at that time.

I have read and understand this policy (please initial): _____

Clients Who Are Dependents:
If you are requesting services as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your dependent's counselor, it is important that the client is able to completely trust me. As such, I keep confidential what the dependent says in the same way I keep confidential what any client says. As the parent or guardian, you have the right and responsibility to question and understand the nature of activities and progress with the dependent, and I must use discretion as to what is an appropriate disclosure. In general, I will not release specific information that the dependent provides to me; however, I feel it is appropriate to discuss your dependent's progress in broader terms and value your participation in their counseling experience.

In the event that the dependent has parents who are divorced or is going through a custody battle, I require that a parenting plan be presented prior to treatment beginning. If the parenting plan requires that both parents must give consent over treatment and decisions for the child, it will be required that both parents sign all opening paperwork.

I have read and understand this policy (please initial): _____

ROOTED RESILIENCE
COUNSELING

Insurance:
I do not file insurance claims. I am NOT paneled by any insurers. If your insurance provider or another third party will be covering the cost of your counseling, then you need to make arrangements with them to reimburse you directly. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to the insurance company. We are willing to fill out any part of the form that is necessary.

(This may include additional fees and does not insure that they will reimburse you.)

I have read and understand this policy (please initial): _____

I look forward to our work together and highly encourage your feedback as we collaborate on your specific therapeutic goals. Please sign and date below to confirm that you have read, understand, and agree and have had an opportunity to ask questions regarding the policies outlined above.

I have read the Practice Policies and agree to abide by the terms. (circle one) **yes** **no**

Print Name_____

Signature_____ ***DATE*** _____