# Katie Holtz-Valencia, MS, LCMFT

## Authorization to treat

I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my, or my child's scheduled appointments and understand that failure to do so more than two times may result in my care being terminated.

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it.

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Client Signature/Responsibility Party Date

## Authorization to treat minor child

Name of Child _____ Date of Birth _____

I warrant that I am a custodial parent of the above named minor child. I hereby give permission for him/her to receive therapy services. I acknowledge that I am aware of the mandating reporting laws in the state of Kansas. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all therapy services for my child.

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Client Signature/Responsible Party Date

## Professional Disclosure Information (HIPPA)

Your signature below indicates that you have read my HIPPA agreement and agree to its terms and serves as acknowledgement that you have received my HIPPA notification form. Not abiding by these policies may lead to termination of our work together and/or referral to another professional. Signature below also gives permission for your therapist to leave phone messages with family members and on voicemail regarding the status of appointments.

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Client Signature/Responsible Party Date

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## Client Rights/Notice of Privacy Practices

**This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**YOU HAVE THE RIGHT:**

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going therapeutic relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action.
9. To request where we contact you (home, work, cell) and whether we should leave a message.

**THERAPISTS' CREDENTIALS:**

Katie Holtz-Valencia, MS, LCMFT, is a Licensed Marriage and Family Therapist in the state of Kansas and a Licensed Marriage and Family Therapist in the state of Missouri. She is bound by the Code of Ethics set forth by the American Association of Marriage and Family Therapists (AAMFT) and other professional governing boards, and clients can request a copy of these ethics at any time.

**CONFIDENTIALITY OF INFORMATION:**

Laws insuring your right to privacy protect matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is known or suspected (reporting is required by law).
2. When the abuse of an elderly or depended person is known or suspected (required by law)
3. If you commit a crime against a staff member of another person in the premises,
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.
6. If you are under 18, your parents may be informed about your care when it is in your best interest and not considered to be harmful after you are informed that this information will be released;
7. For the purpose of audits and program evaluation by internal or external insurance & billing sources.

**SECURITY OF RECORDS:**

Your records of treatment and related financial records are kept confidential. Records will not be made available to others without signed authorization by the client to release information. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by state and federal laws and the ethics of the counseling professions as private information. All adults present in couples or family sessions have to authorize the release of records. Clients have access to their therapy records, with certain exceptions as required by HIPPA. Therapists recommend reviewing records with clients to avoid misinterpretation. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records. Violation of privacy laws by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Clients have the right to be informed about changes in privacy policies.

**RETENTION OF RECORDS:**
Treatment records are retained for a period of at least 10 years following the termination of treatment. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

**INFORMATION REGARDING PSYCHOTHERAPY:**

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well-being may also occur.
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client's psychological functioning.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. An attempt to provide treatment that is realistic in both areas will be made.
4. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; recommendations will be made if they are appropriate, based upon assessment.

**TERMINATION OF THERAPY:**
A client may be terminated from therapy non voluntarily if (a) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, (b) the client refuses to comply with treatment recommendations, (c) the client does not make payment or payment arrangements in a timely manner. Clients may voluntarily leave treatment at any time, and, it is recommended that clients discuss this with the therapist in person. This will help facilitate a more appropriate plan for discharge.

**OFFICE HOURS/EMERGENCIES:**
This therapist has set office hours and therapy sessions that are by appointment only. I am unable to provide therapy services to clients who require 24 hr. care/crisis intervention services, and may be unable to provide immediate crisis intervention or emergency assistance. I check my confidential voicemail, and strive to return phone calls promptly. When appropriate for treatment needs, I do offer parenting, marital, and personal "coaching" calls to support clients meeting their therapy goals outside of session. This is considered personal therapy over the phone tailored to meet clients' individual needs. See Financial Policies for fees associated with such calls. For medical or life-threatening emergencies, call 911 or contact nearest emergency room at your local hospital. **Do not use email or texting as methods to communicate that you are in crisis with your therapist.** Texting and email are often appropriate for scheduling communication; for further information sharing or questions, communicate with your therapist by phone or in session.

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Client/Guardian Signature Relationship to Client Date

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Client/Guardian Signature Relationship to Client Date

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Therapist Signature Date