Kate the Cownselor

Katheryn Kiker, LPC-Associate
Counseling@sweettimesonthefarm.com
(409)234-4144| License #93015
Supervisor: Kimberly J. Benedict, MS, LPC-S, #61852

Thank you for your interest in becoming a client! The following form is called the informed consent, giving you the information you need before you begin the counseling relationship. It will need to be filled out and electronically signed before your first appointment.

This form includes:

3 pages for you to fill out your personal information
6 pages of reading that outlines what you are agreeing to in receiving counseling
2 pages of initialling/signing

Please take your time in going over it. If you have any questions about any part of the form, please email me at counseling@sweettimesonthefarm.com or call/text at 409-234-4144

For parents/guardians,

Fill out this form on behalf of your child. At the bottom of the form, you will type their legal name and electronically sign with your signature.
Please send custody agreement paperwork to my email:
counseling@sweettimesonthefarm.com

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CLIENT INFORMATION

Legal Name: _____

Date of Birth:_____ **Guardian Name** (minors):_____

Address: _____

City: _____State:_____Zip:_____

Primary Phone: _____ Secondary Phone: _____

May I leave voicemails at primary number? Yes No
Text Messages for primary number? Yes No
Leave voicemails at secondary number? Yes No

Email Address:_____

How were you referred? Personal reference Google Search Social Media

Psychology today Other: _____

Emergency Contact Name:_____

Relationship:_____ Number: _____

Permission to call: Yes No Restrictions?:_____

Secondary Client's Name (couples/family):_____

Date of Birth: _____ Email:_____

Minor Clients of Divorced Parents
Has the other parent been informed about the minor receiving counseling?
Yes No
Do you agree to send me a copy of the custody agreement for the clients file?
Yes No

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HEALTH HISTORY

1. Primary Care Physician: _____ Phone Number:_____

2. Serious Medical Illness/Accidents:

_____

3. Are you currently on any medications? Yes No
If yes, please list names and dosages:

_____

4. Surgeries or operations?: Yes No

_____

5. Any hospitalizations? Yes No
If yes, when and for what reason:

_____

6. Have you ever been treated for depression/anxiety? Yes No
If yes, by whom?

_____

7. Have you had any previous counseling? Yes No
If yes, with whom and when?

_____

8. Are you or have you been in the care of a psychiatrist? Yes No
If yes, with whom and when?

_____

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9. Have you ever been treated for alcohol or drug abuse? Yes No
If yes, when and where?

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10. Have you been the victim of physical or sexual abuse? Yes No

11. Do you have suicidal thoughts? Yes No

12. Have you had a suicidal attempt? Yes No
If yes, when?

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13. Do you or have you had an eating disorder? Yes No

14. Do you have a history of infectious diseases? Yes No
If yes, please describe:

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15. Do you have any allergies? Yes No
If yes, please describe:

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16. Is there past or present nicotine use? Yes No

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Informed Consent to Treatment & Privacy Practices

Please read and sign. Keep one copy for your records.

To contact my supervisor:
Kimberly Benedict, LPC-S, License #61852
P.O. Box 2304, Boerne, TX, 78006
361-816-2327 Phone 830-336-4060 Fax
kimberly@cedarcrossing.care

COUNSELING PURPOSES, GOALS, AND TECHNIQUES

Counseling is an interpersonal process unlike any other service you receive from a health professional. The client and counselor both have a significant role in helping the client reach therapeutic goals. According to research, here is the breakdown of responsibility that both parties bring to the table (for reference: Asay & Lambert, 1999; Lambert & Ogles, 2004)

40%– The largest contributor of client change is what the client brings into counseling. Your personal strengths, choices, values, supports, resources, and willingness. Continual engagement with your therapeutic goal in and out of sessions is what makes the biggest difference.

30%– The relationship between client and counselor. Having a great relationship with your counselor can help you feel accepted, validated, respected and heard. This caring space is hopefully helping you make some room to examine your life honestly. It is important that you like your counselor and feel safe sharing things with them.

15%– The amount of hope that the client brings into the relationship. Your experience with your counselor and putting in the work may gradually increase your levels of hope before you even realize you are ready to believe you're capable of change.

15%– The theory and techniques used by the counselor. Each counselor tends to gravitate toward theoretical orientations and certain client issues are better suited for certain techniques. The theory I am generally most guided by is humanistic theory (also called Rogerian or person-centered.) Humanistic counselors believe people grow when given an environment of acceptance and empathy, and believe people naturally become more healthy when they accept themselves fully for who they are.

LIMITS OF CONFIDENTIALITY

The purpose of confidentiality is so that you are encouraged to say all the things that are on your mind. There are exceptions to confidentiality defined in the state and federal statutes.

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The most common of these exceptions suicidal or homicidal threat, when the court issues a subpoena, or when child or vulnerable adult abuse or neglect is involved. As a therapist licensed by the state of Texas, I must report these issues to DFPS or CPS, and I fully cooperate with the requests of Law Enforcement and CPS/APS.

Instances where I *cannot* protect confidentiality

- If I believe you are a danger, physically or emotionally to yourself or another person, I will contact a person who may prevent the danger. In signing this consent form, you authorize your clinician to warn the person in danger and to contact any person in a position to prevent harm to you or another person, including medical and law enforcement personnel.
- If you tell me you are being abused physically, sexually, or emotionally, or if a minor has been abused in the past
- If you disclose that you knowingly access, reproduce, view or distribute any material in which a child is engaged in an act of sexual conduct
- If you are involved in a court/legal case and a request is made for information about your counseling or your therapy

How I *will* protect confidentiality

- Information shared by you in session may be written in my session notes, but will be kept confidential and stored in a double locked area if printed, or a HIPAA compliant electronic method.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law via subpoena
- I will not disclose any information about you being my client to anyone outside of staff that may be hired, or my supervisor.
- I will ask how you would like communications, such as voicemails and text messages.
- In the event of my death or incapacity, or the termination of my counseling practice, custody and control of client's mental health records would go to my supervisor, Kimberly Benedict, LPC-S. As my supervisor she will be knowledgeable of your case and will contact you in writing and refer you to other appropriate counselors.

Children/Adolescent Confidentiality

A person aged seventeen (17) or younger seen in this office must have the signature of a parent. In the case of divorce or shared custody, the consent and authorization must be signed by the guardian maintaining sole/primary custody, or one of the guardians maintaining joint/shared custody.

If custody is shared by 2 or more parents/legal guardians, the guardian presenting the child/adolescent for treatment must inform the other guardian(s) that the client is in therapy treatment. Please be prepared to provide a copy of the most current custody papers before we begin treatment.

RIGHTS AND RISKS

As with any treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will for a time, have uncomfortable levels of

sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in your community may mistakenly view anyone in therapy as weak, or perhaps as seriously disturbed. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk therapy may not work out well for you. You have the right to ask questions about any aspect of the therapy process. You have the right to expect that your therapist will maintain professional and ethical boundaries with you and in your treatment. If therapy with me is not successful, I will recommend a more appropriate therapist or counseling agency.

TERMINATION AND DISCHARGING FROM SERVICES

As a client, you have the right to end your therapy at any time, for whatever reason. If you chose to end therapy with me, there are no further obligations, except for finalizing payment for all services already rendered.

I also have the right to discharge clients for reasons such as meeting their therapeutic goals, if the client no longer is benefitting from services, or the therapeutic relationship is no longer beneficial or safe. ***I will automatically discharge in the event that a client goes 30 days with no contact and no session.***

CLIENT/THERAPIST RELATIONSHIP

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions. This includes any and all personal social media contact. The ACA Code of Ethics prohibits professional counselors from engaging in virtual relationships with individuals with whom they have a counseling relationship; this includes Facebook, Snapchat, Instagram, LinkedIn, and other forms of social media. I have professional social media pages which you are welcome to follow and give reviews on my google business profile, website, and facebook. I do not communicate with clients over social media and if comments are posted publicly that make it known that you are my client, or that are revealing of our relationship in some way I will delete them. I do not allow clients in my personal social media pages.

Our area is small and so it can be somewhat inevitable that you may see me in public. I will not approach you if I see you publicly so that you do not have to explain to anyone our relationship, and I'd like you to know this upfront so that you don't think I'm ignoring you! However, if you choose to approach me I am happy to say hello, and if you are with others, I will not say I am your therapist, but you are welcome to disclose what you are comfortable with.

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COMPLAINTS

I am open to your feedback and hope that you become comfortable sharing with me concerns or complaints you have with me or my business processes.
However if you believe your rights or privacy have been violated, you can report your complaints to my supervisor, whose contact information is at the beginning of this informed consent document, or the Texas State Board of Examiners of Professional Counselors at 1-800-942-5540 or by writing to Complaints and Management and Investigative Section, P.O. Box 141369, Austin, TX, 78714-1369.

TECHNOLOGY AND THERAPY

"Telehealth Services" encompasses Video Therapy and Telephone Counseling. Telehealth involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician employed by or otherwise contracted with Katheryn Kiker, LPC-Associate and a client who are not in the same physical location. Telehealth Services may be used for diagnosis, treatment, follow-up and/or education.

Setting up for Telehealth Sessions
To participate in Video Therapy, you will need a secure internet connection with at least 1mb of bandwidth and a computer, phone, or tablet with a video camera and microphone. Katheryn Kiker, LPC-Associate uses Google Meet to provide secure, confidential video therapy to my clients. You can learn about Google Meet here: meet.google.com

Privacy with Telehealth Sessions
To ensure your privacy in Telehealth Services, your Provider will connect with you from a space where she/he can reasonably ensure confidentiality and lack of interruption. Your Provider may use headphones and/or sound machines to enhance your privacy. It is your responsibility to make sure that no one is in the room where you are holding the session and to not be conducting other activities such as driving. Clients are not allowed to record conversations or any part of a therapy session without my written consent.

EMERGENCIES

This office is not an emergency or crisis treatment provider. If you have an urgent situation, I invite you to call and leave a brief but detailed message, or send an email. You can expect a call back within 24 hours during my available office hours Monday-Friday. True emergencies should be directed to the community emergency services (911), the nearest hospital/emergency room, or to the local hotlines, which are available 24 hours a day/7 days a week.
National Suicide Prevention Lifeline: 1-800-273-8255 | Suicide Prevention Hotline: 1-800-784-2433

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APPOINTMENTS

Initial Consultation sessions usually last a little over an hour, and will be led by the counselor to discuss historical information. After the Initial Consultation, regular psychotherapy sessions are 50 minutes in length. I will give my recommendation for frequency after our first session, discuss any assessments needed or potential referral if I am not the right fit.

Notification of Cancellations/Rescheduling

Please make every effort to notify me more than 24 hours ahead of the scheduled appointment time. You can do so by call, email, or text. Late cancellations and no shows will be charged a fee, amount listed below. If this occurs more than twice, you will be charged the full fee.

If you arrive late, I unfortunately cannot extend your session time, as there are likely other sessions scheduled after yours. Repeated late cancellations or missed appointments may result in termination of services. I am diligent about being on time for my appointments but if I do run into emergencies or am late for any reason, I will make up the time with you at our next scheduled appointment or squeeze in another appointment at no charge.

FEES AND PAYMENT

—--- Session fees —---

60-min Initial Consultation Session	(Individuals)	$100
50-min Individual Psychotherapy Session		$85
60-min Initial Consultation Session	(Couples)	$110
50-min Couples Psychotherapy Session		$95

—---- Miscellaneous fees —---

No Show or Cancel less than 24 hr Notice	$25
Parent Consult (30 min)	$45
Parent Consult (50 min)	$65
Referrals	free
Phone Calls less than 15 minutes	free
Phone Calls more than 15 minutes	$25
Email once or twice per week	free
Emails multiple times per week	$25
Emotional Support Animal Letter	$45
Copies of files 20+ pages	$35
Disability/FMLA Paperwork	$40
Unlimited texts, emails, and calls	$150.00/month + session fees

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Payment

Payment is due at the time of session. A text will be sent to you via IVY Pay the date of your first session. This service is HIPAA compliant and collects your credit card information once, and for following sessions the card on file will be charged. You are always able to change the card you are using. If any issues arise it can be addressed, unless otherwise discussed and agreed upon ahead of the session.

As an LPC-Associate I do not currently accept insurance, however I can provide a superbill for reimbursement and I do offer a sliding scale that considers income and family size.

If there are any concerns with my fees, billing, your insurance, or any other money related point, please bring it to my attention. I will do the same with you. Such problems can interfere greatly with our work and must be worked out openly and quickly.

COURT AND LEGAL INVOLVEMENT

My emphasis is providing therapy and helping clients/families identify strengths and resources to overcome crises and life's situations. Therefore, I would prefer not to be included in cases involving litigation. All court appearances (including any requested appearance, subpoenaed appearance, settlement conference, or deposition) require additional fees which are due at least one week before the scheduled appearance. Please understand that you will be held responsible for court related fees should they occur.

Court Fees are as follows:

- $500 per day (for case preparation/court time)
- Written case summaries are $40 per case summary.
- Charges associated with these services will be due immediately and prior to any professionals/parties receiving my therapist's documentation or services
- Please note: if an appearance request is received without a minimum of one week notice, the appearance fee is due immediately and there will be an additional $200 express charge.
- Failure to provide the fee as specified, constitutes release from the requested appearance.

HIPAA

The HIPAA NOTICE OF PRIVACY PRACTICES details the considerations regarding confidentiality, privacy, and your records, and can be reviewed on my website: katethecownselor.com/current-clients/

This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the HIPAA NOTICE OF PRIVACY PRACTICES may be revised. Any changes to these privacy practices will be posted in my office, but you will not receive an individual notification of the updates. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.

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_____ Initials I have read the HIPAA NOTICE OF PRIVACY PRACTICES, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the HIPAA NOTICE OF PRIVACY PRACTICES is incorporated by reference into this agreement.

IN PERSON SERVICES LIABILITY WAIVER

In exchange for participation in the activity of "Cownseling" and/or "Nature Therapy" services on the farm, organized by Sweet Times on the Farm, LLC and Katheryn Kiker LPC-A of 9404 Gaulding Rd, Beaumont TX 77705, and use of the property at 14183 TX-124, Beaumont TX 77705 facilities and services of Sweet Times on the Farm, LLC and Katheryn Kiker, LPC-A, I agree for myself and (if applicable) for the members of my family, to the following:

_____ **Agree to Follow Directions.** I agree to follow any oral instructions or directions given by employees, representatives, or agents of Sweet Times on the Farm, LLC and/or Kaheryn Kiker, LPC-A

_____**Assumption of the Risks and Release.** I recognize there are certain inherent risks associated with the above-described activity, and I assume full responsibility for personal injury to myself, and further discharge Sweet Times on the Farm, LLC for injury, loss, or damage arising out of my use of or presence upon the facilities of Sweet Times on the Farm, LLC, whether caused by the fault of myself, or other third parties.

_____**No Duress.** I agree and acknowledge that I am under no pressure or duress to sign this agreement and that I have been given a reasonable opportunity to review it before signing. I further agree and acknowledge that I am free to have my own legal counsel review this agreement if I so desire. I further agree and acknowledge that the provider will refund any fees I have paid to use its facilities if I choose not to sign this agreement.

_____**Acknowledgment of Natural Setting.** I acknowledge that the farm I am visiting is a working farm in a natural setting, and I will respect employees working. I could be exposed to elements, including but not limited to: intense heat and cold, muddy conditions, unsteady ground, cow manure, etc. By signing I am agreeing that I am aware of the setting and take responsibility for my capability of navigating the setting.

_____**Weather Policy.** I acknowledge that there are limitations with inclement weather that affect my ability to meet in-person. Cownseling and Nature Therapy sessions are expected to be transferred to virtual sessions in the case of bad weather, to keep continuity of therapeutic goals. If you choose to cancel instead of moving to a virtual session, it will be considered a late cancellation and you will be charged the fee. The decision to switch to virtual based on weather will be made no later than 1 hour before your appointment time. *Emergencies: In the case that there is extreme weather such as flooding or a hurricane, this would be considered an emergency and the late cancellation policy does not apply.*

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AGREEMENT

I understand and agree to abide with this Informed Consent to Treatment & Privacy Practices. I have read and clearly understand the above information included in this document. This agreement will remain in effect until termination of services with Katheryn Kiker, LPC-A. I have read the notice of Privacy Practices and Clients' Rights documents. I have been offered a copy of these policies to take with me if desired.

Client's Signature:

_____ Date: _____

Parent/Guardian's Signature (minors):

_____ Date: _____

Therapist Signature:

_____ Date: _____