Consents and Agreements

Risks and Benefits of Therapy

It is important that you understand that counseling has both benefits and risks. You may experience uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Your therapy may also involve recalling unpleasant aspects of your history. Additionally, difficulties with people important to you may occur, family secrets may be disclosed, and despite our best efforts, therapy may not work out well. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and resolutions of specific problems. In other words, for many people things can feel uncomfortable and more difficult before they start to feel better. I can make no guarantees about how the therapy process will be for you specifically.

Therapist Communications

I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking the appropriate choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may call me: NAME: _____

☐ At my home. My home phone number is: _____ Message Ok? ☐ Yes
☐ On my cell phone. My cell phone number is: _____Message Ok? ☐ Yes
☐ At work. My work phone number is: _____ Message Ok? ☐ Yes

My therapist may:

☐ Send mail to me at my home address.
☐ Send mail to me at my work address.
☐ Communicate with me by email. My email address is: _____
(I understand that e-mail is not a completely private form of communication).

In case of emergency, I prefer my therapist contact (PLEASE PRINT):

_____ _____ _____
Name Relationship to Client Best Phone Number

FOR COUPLES THERAPY ONLY: Partner Information – NAME: _____

My therapist may call me:

☐ At my home. My home phone number is: _____ Message Ok? ☐ Yes
☐ On my cell phone. My cell phone number is: _____Message Ok? ☐ Yes
☐ At work. My work phone number is: _____ Message Ok? ☐ Yes

My therapist may:

☐ Send mail to me at my home address.
☐ Send mail to me at my work address.
☐ Communicate with me by email. My email address is: _____
(I understand that e-mail is not a completely private form of communication).

Consent for Treatment

Please ask your therapist to address any questions or concerns that you have about this information before you sign! Upon reading and understanding these policies, please sign below.

Your signature indicates that you:

- Downloaded, carefully read and understand the contents of the Disclosure Statement and Agreement for services from Julie Kyker, MFT at Compassionate Heart Couples Counseling (dated September 30, 2014).**
- Downloaded, read the Privacy Practices of Julie Kyker, MFT at Compassionate Heart Couples Counseling (dated 9/30/14) and that you have kept a copy for your records if you so desire.**
- Downloaded, read and understand the Social Media Policy of Julie Kyker, MFT at Compassionate Heart Couples Counseling (dated 9/30/14).**

- Agree with the fee arrangements and terms of confidentiality and that they have been clearly made.
- Consent for treatment with Julie Kyker, MFT
- I agree to all terms stated in the above documents.

_____	_____	_____
Printed Name	Client Signature	Date
_____	_____	_____
Printed Name	Client Signature	Date
Julie Kyker, MFT	_____	_____
Therapist Printed Name	Therapist Signature	Date

**NOTE: The first three (3) items are enclosed in one document entitled "Kyker Policies and Privacy Practices 9-30-2014"

Compassionate Heart Couples Counseling
Julie Kyker, MFT

Medical insurance may pay for part of your counseling services. In order for me to bill your insurance you must have a diagnosable mental health disorder (this is because health insurance is built on a medical model of treatment and rarely pays for prevention). We will go over this information in our first session…common diagnoses in my practice include: forms of depression disorders, anxiety disorders and adjustment disorders.
I am a contracted provider with Anthem BlueCross and Aetna. All other insurance must be PPO plans that allow you to see providers outside of their network.

Client	LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	AGE	SEX

PRIMARY INSURANCE			
PRIMARY INSURANCE	INSURANCE ADDRESS & TELEPHONE		
SUBSCRIBER'S NAME (who's insurance is it?)	RELATIONSHIP TO PATIENT	INDICATE PERSON TO DISCUSS BILLING ISSUES:	
SOCIAL SECURITY NUMBER of Subscriber	ID #	GROUP/PLAN NUMBER (COPY OF INSURANCE CARD NEEDED)	EFFECTIVE DATE
IS YOUR CONDITION WORK RELATED?	Compassionate Heart Counseling does not accept Workers Comp. Please initial ____		

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ AND AGREE TO THE CONDITIONS BELOW.

The undersigned understands that s/he is responsible for verification of insurance benefits on any policy(s). Julie Kyker/Compassionate Heart Couples Counseling shall be held harmless should the account be rejected by the insurance carrier(s) in whole, or in part. It is the undersigned's responsibility to understand and confirm insurance policy limitations and/or exclusions directly with the policy holder.

The undersigned certified that s/he has read the foregoing and received a copy thereof, and is the client, or is duly authorized by the client as the client's general agent to execute the above and accepts the terms, and does hereby assume responsibility for the payment of all charges for such services.

I hereby authorize Julie Kyker to release all information; including psychiatric, drug and/or alcohol, concerning my case to my insurance company or other third party payer, funding sources or their agent for payment or review. This consent may be revoked unless it has already been relied on and if not earlier revoked shall terminate when disclosure is no longer reasonably necessary to effect the purposes outlined above. Information will not be released to any other source without the client's prior approval.

I/WE AGREE TO THE CONDITIONS AS SET FORTH ABOVE AND IN THE PROFESSIONAL DISCLOSURE STATEMENT.

CLIENT DATE

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes direct payment to Julie Kyker of any insurance benefits otherwise payable to or on behalf of the undersigned for this service, at a rate not to exceed Julie Kyker's regular charges. Furthermore, I hereby assign any and all sums of money payable to me under the terms of any insurance policy, contract or other third party entitlement on account of the services rendered by Julie Kyker. It is agreed that payment to Julie Kyker, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that s/he is financially responsible for charges not covered by this assignment. It is also understood that this authorizes Julie Kyker to retain my signature on file for all insurance claims submitted for subsequent admissions, in compliance with the signature on file provisions of third party carriers. This assignment is irrevocable.

SIGNATURE OF INSURED_____DATE_____

Permission for Digitally Videotaping Couple Therapy Sessions

As a primary tool in couple's therapy, and in order to augment your therapy work, I use videotape feedback as part of the therapy sessions. This means that I may ask to videotape you during specific dialogues or exercises, or during entire sessions. Sometimes we will play back these tapes in session to help you see patterns of behavior between the two of you and to help you process conflicts. By viewing the videotape in session, it allows us to "stop action" and help identify what cues you experience that trigger uncomfortable feelings. It also allows you to witness your progress as your relationship becomes more satisfying to both of you.

In addition to in-session use, I may wish to use the videotape to receive consultation from my EFT consultant. This may occur during the time of treatment or thereafter for purposes of peer review, education and quality assurance. All matters discussed in consultations will remain completely confidential.

These tapes are my property and will remain solely in my possession during the course of your therapy. Should you wish to review these tapes for any reason, we will arrange a session to do so.

By signing below, I consent to the video taping of therapy sessions with Julie Kyker, MFT. I am aware of the presence of the video equipment and permit the use of all or part of the video tapes for the purpose of (please initial below the type of use you are permitting):

____ ____ Our therapist review and our review of our case to assist in our therapy.

____ ____ Our therapist my use segments of the tape in EFT consultation.

____ ____ Our therapist may use the session to submit for EFT certification.

We understand that in all cases above, our confidentiality will be maintained. In no way will the refusal to grant consent for this videotaping affect our therapist decision and willingness to help us. If at any time during the treatment process, we wish to stop the taping we may do so and still continue treatment.

_____	_____	_____
Printed Name	Client Signature	Date
_____	_____	_____
Printed Name	Client Signature	Date
Julie Kyker, MFT	_____	_____
Therapist Printed Name	Therapist Signature	Date