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OUTPATIENT SERVICES CONTRACT

Welcome to Willow Tree Wellness, LLC. Since this is your first visit, we hope what is written here can answer some of your questions as you seek therapy. Please ask if you need clarification on any of the topics discussed in this Outpatient Services Contract. Also, ask if you have questions that are not addressed in this contract. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

PSYCHOTHERAPY SERVICES

We provide psychotherapy services for children, adolescents, adults, couples and families. The first appointment serves as an intake appointment. We want to hear about the difficulties that led to you making an appointment, goals for therapy, general information about yourself and your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help. If we do not think we are able to best assist you, we will provide you with information on who we believe would work well with your particular issues. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know. We will do our best to suggest a different therapist who may be a better fit.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples, and family therapy sessions last 45-60 minutes, unless otherwise arranged. During your first initial appointment, you and your therapist will work together to set a frequency of visits. Frequency of therapy visits can vary based on what seems most appropriate for your particular situation.

Therapy can be extremely helpful and fulfilling. It takes work both in and out of sessions to be most effective. It requires active involvement, honesty and openness in order to change thoughts, emotional reactions and/or behaviors.

There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication, stability in relationships and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore and changes in dynamics or communication with significant people in your life.

Although there are many benefits to therapy, there are no guarantees of positive or intended results. If during your work together with your therapist, noncompliance with treatment recommendations becomes an issue, we will make an effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. We encourage you to discuss any concerns you have about our work with your therapist directly. Open and honest communication builds a

therapeutic relationship. Factors that may result in termination of therapy may include but are not limited to, violence or threats towards your therapist or refusal to pay for services.

Deciding when therapy is complete is meant to be a mutual decision. We will discuss how to know when therapy is nearing completion. We may mutually decide to schedule less frequently to gradually end therapy.

We may at times seek consultation with other therapists to ensure we are helping you in the most effective manner. We will give information only to the extent necessary. We make every effort to avoid revealing the identity of our clients. The consultant is also under a legal and ethical duty to keep the information confidential.

AVAILABILITY BETWEEN SESSIONS

If needed, you can leave your therapist a message on their office line located on the back of their business card. When you leave a message, include your telephone number even if you think we already have it. Please let us know the best times to reach you. We make every effort to return calls in a timely manner. If you do not hear back from us within one business day, please leave a second message.

If you are in an emergency situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. Additional help is available by dialing 988. Willow Tree Wellness, LLC is not a crisis facility. Do not contact us by email or fax in an emergency, as we may not get the information quickly.

RATES AND INSURANCE

Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits, so you understand your coverage prior to your appointment. Some insurance companies require a precertification before the first appointment, or they will not cover the cost of services.

Our current fees are as follows:

- Initial Intake Appointment: $240.00
- Counseling Sessions: $165.00
- Patients with insurance: the negotiated rate with each insurance company

We also provide telephone and online therapy sessions. Some health insurance carriers cover telehealth (telephone/online therapy). If your insurance plan does not cover teletherapy, it is your responsibility to pay our full rate of $165 per session if you opt for teletherapy.

We are happy to assist you by having our staff file claims to your insurance company on your behalf. However, you are responsible for payment of the fee for therapy, not your insurance company. Acceptable forms of payment include cash, check and major credit cards. Payment is expected at the time of service. **Cancellations or missed appointments without 24 hours notice will be subject to a $50 cancellation fee. Insurance companies do not pay charges for missed appointments.** If fees for services are not paid in a reasonable amount of time and attempts have been made to resolve the financial matter to no avail, a client's services could be terminated.

We check your insurance benefits as a courtesy for our clients. There are times when insurance misquotes your benefits. In the event of a misquote, clients are still responsible for your copay/coinsurance/deductible amount that insurance reports after claims are submitted. You can call your insurance company to check your own benefits by calling the number on the back of your insurance card.

Most insurances require you to authorize us to provide a clinical diagnosis and sometimes additional clinical information. This information will become part of the insurance company's files. Insurance companies claim to keep information confidential, but you should check with your insurance company directly if you have questions about their confidentiality practices.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current or former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications. There is a possibility that we will not get the message in a timely manner, or that communication will be interpreted unclearly. If you need to contact your therapist between sessions, please call their office line located on the back of their business card. Text messages and emails are only to be used for scheduling purposes.

PROFESSIONAL RECORDS

Both law and the standards of our professional licensures require we keep appropriate treatment records. If we receive a request for information about you from a 3rd party, you must

authorize in writing to release the requested information. This is called a Release of Confidential Information.

CONFIDENTIALITY

In general, there are laws that protect the confidentiality of all communication between you and your therapist. We only release information to others with your written permission. More information about your protected health information is provided in your HIPAA statement. However, there are a number of exceptions, which are indicated below.

In judicial proceedings, if a judge orders your records released, we have to release records. We are also ethically and legally required to take action to protect others from harm even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action through notifying the potential victim, the police, and/or facilitating hospitalization. In these situations, we make reasonable effort to discuss any need to disclose confidential information with you. We are happy to answer any questions you have about the exceptions to confidentiality.

MINORS

If you are under 12 years of age, please be aware that the law may provide your parents the right to look at your treatment records. If you are between the ages of 12 and 18, the law is more limiting on your parents' right to examine your treatment records. After being informed of your parents' request, if you do not object or your therapist does not find that there are compelling reasons for denying the access to the records, information will be provided to your parents. Your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving your parents any information, your therapist will discuss the matter with you. We will do our best to process with you any objections or concerns that you may have before disclosing information to your parents.

COURT RELATED SERVICES

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (related to a legal matter that you are involved in) please note the following:

- We charge a $1500 retainer prior to any preparation or attendance of legal proceedings

- We charge $165/hour to prepare for and/or attend any legal proceeding and for all court related services.
- A flat fee for record requests will be $30.00. Payment is required before documents will be released.
- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If the court or an attorney does not pay our fees, you will be charged for the time we spend responding to legal matters.
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to, fees we are charged for legal consultation and/or representation by our attorneys.
- Please note, that a subpoena or court appearance by your therapist may not be in your favor. Therapists are only allowed to discuss facts of the case and professional opinions. Often, it is more appropriate for your attorney to request a letter or "Progress Summary" instead of a subpoena. This letter or summary may save you time and money. However, you will be liable for the cost of such documents.

COMPLAINTS OR QUESTIONS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your concerns seriously, openly and respond respectfully.

A FINAL WORD

The counseling relationship is a personal and individualized partnership. We want to know what you find helpful and what, if anything, may be getting in the way. We want you to feel free to share with us what we can do to help.

I understand and have been informed that my therapist has the following licensure and is bound by the Code of Ethics of their respective profession:

[ ] LMSW - Licensed Master Social Worker*
[ ] LMFT - Licensed Marriage and Family Therapist*
[ ] LSCSW - Licensed Specialist Clinical Social Worker*
[ ] LCMFT - Licensed Clinical Marriage and Family Therapist*
[ ] LCAC – Licensed Clinical Addictions Counselor*
[ ] RPT – Registered Play Therapist**

* = Licensure is governed by the Kansas Behavioral Sciences Regulatory Board (BSRB).
** = Certification governed by the Association of Play Therapy (APT).

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and mental health operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. **"Protected health information"** is information about you. This includes demographic information that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing mental health services to you. It is also used to pay your health care bills, to support the operation of this agency's practice and any other use required by law. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your mental health care and related services. This includes the coordination or management of your mental health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include but are not limited to quality assessment and employee review, etc. For example, we may call you by a name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation and Inmates. Under the law, we must also make disclosures to you when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If a therapist believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another mental health professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and may provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

III. Complaints

You may file any complaints with our office staff, at 316-779- 2560, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. ***We ethically and legally cannot retaliate against you for filing a complaint.***

Outpatient Services Contract

Please ask before signing below if you have any questions about psychotherapy or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

I have read and agree to the terms in the outpatient services contract (pages 1-5).

Client Name: _____

Client Signature: _____Date: _____

Guardian Signature (if minor): _____Date: _____

Guardian Signature (if minor): _____Date: _____

Notice of Privacy Practices

I have read the notice of privacy section (pages 6-7).

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Demographic Information

Client Legal Name:	Date:
Client Preferred Name:	Preferred Pronouns:
Legal Sex: M ☐ F ☐ *While Willow Tree Wellness, LLC recognizes a number of genders / sexes, many insurance companies do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.	
DOB:	Email: ☐ Check box if you would like appointment reminders to be sent to the above email address.
Client Address:	
Best number to reach you:	May we leave a message / text? ☐ Yes ☐ No ☐ Check box if you would like appointment reminders to be texted to this number.
Primary Insurance:	Secondary Insurance:
Subscriber's Name / Date of birth / Relationship to client:	
Current Employment Information (Employer, Occupation, how long have you worked there)?	
Current Marital Status:	
Current school / highest level of education obtained:	

Emergency Contact/Guardian Information

Name:	Relationship to client:
Address:	Phone Number:

Additional Information

Current reason for seeking therapy?
How did you hear about us?
Please list any medications/doses:
Please list any previous therapy experience:
Have you ever been knocked out or lost consciousness? (if yes, please list)
Current medical conditions / Allergies:
Current or past legal problems:
Family psychiatric history (any family member been diagnosed with a mental illness? Has anyone in your family been hospitalized due to a psychiatric condition?)

Current Behavioral Symptom Checklist

Symptom Key:

Mild = Impacts quality of life, but not significant day-to-day impairment
Mod (Moderate) = Significant impact on quality of life and/or day-to-day functioning.
Sev (Severe) = Profound impact on quality of life and/or day-to-day functioning.
Past = Experiences in the past, but not within the last 6 months. Client Name: _____

Symptoms	Mild	Mod	Sev	Past	Symptoms	Mild	Mod	Sev	Past
Depressed Mood	☐	☐	☐	☐	Appetite Decrease	☐	☐	☐	☐
Appetite Increase	☐	☐	☐	☐	Guilt	☐	☐	☐	☐
Sleep less / too much	☐	☐	☐	☐	Elevated Moods	☐	☐	☐	☐
Bowel or Urinary issues	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Fatigue / Low energy	☐	☐	☐	☐	Dissociations	☐	☐	☐	☐
Feeling Slowed Down	☐	☐	☐	☐	Physical or body complaints	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐	Self-harming behaviors	☐	☐	☐	☐
Poor Grooming	☐	☐	☐	☐	Significant weight loss	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐	Medical Conditions	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Emotional trauma	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Physical trauma	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Sexual Trauma	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Substance use/abuse	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	Suicidal/Homicidal thoughts	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	Racing thoughts	☐	☐	☐	☐
Obsessions &/or Compulsions	☐	☐	☐	☐	Poor task completion	☐	☐	☐	☐
Binging and/or Purging	☐	☐	☐	☐	Learning Disability	☐	☐	☐	☐
Laxative/Diuretic abuse	☐	☐	☐	☐	Developmental Disability	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Property destruction	☐	☐	☐	☐
Paranoid thoughts	☐	☐	☐	☐	Social Awkwardness	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Gambling	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Spouse/partner violence	☐	☐	☐	☐
Aggressive Physical Behaviors	☐	☐	☐	☐	Peer Relationship conflicts	☐	☐	☐	☐
Aggressive Verbal Behaviors	☐	☐	☐	☐	Parent/child relationship conflict	☐	☐	☐	☐
Childhood Behavior Problems	☐	☐	☐	☐	Infidelity	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐	Sexual orientation concerns	☐	☐	☐	☐
Grief/loss	☐	☐	☐	☐	Gender identity concerns	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Legal problems	☐	☐	☐	☐
Helplessness	☐	☐	☐	☐	Financial problems	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	Anger issues	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐	Abandonment issues	☐	☐	☐	☐
Sleep maintenance concerns	☐	☐	☐	☐	Low self-esteem	☐	☐	☐	☐
Sleep onset issues	☐	☐	☐	☐	Significant weight gain	☐	☐	☐	☐
Alcohol use/abuse	☐	☐	☐	☐	Impulsive behaviors	☐	☐	☐	☐
Academic concerns	☐	☐	☐	☐	Memory issues	☐	☐	☐	☐
Occupational stress	☐	☐	☐	☐	Bullying	☐	☐	☐	☐
Seasonal depression (SAD)	☐	☐	☐	☐	Nightmares / Night terrors	☐	☐	☐	☐
Other:									