
CHRIS KAEPFNER, PH.D.
Licensed Psychologist

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CONSENT FOR TREATMENT

5122-27-05C

Patient Name: _____ **D.O.B.:** _____

Welcome to my practice. This document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us.

Psychological Services: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

The Benefits and Risks of Therapy: I am an Ohio-licensed Psychologist. I provides a variety of mental health services, with specific services for each patient and his or her family, based upon the needs of that patient and the patient's family. These services may include: individual, family, and/or group treatment; and psychological evaluation. Benefits of these services may include:

- improvement in your behavior
- improvement in your academic performance
- understanding of your learning style
- improvement in your mood
- improvement in family functioning
- determination of treatment needs

On occasion, attempts to work with a patient can result in difficult changes for the him or her and/or family. These difficulties, although occurring rarely, nonetheless constitute a risk to the patient. Problems that may occur include, but are not limited to:

- worsening of your behavior, mood, or school performance
- worsening of family functioning

It is your right to refuse services now or at any point during the course of treatment. Risks associated with refusal of services include:

- worsening of your functioning
- worsening of family functioning
- increased stress to the patient and family due to continued problematic mood or behavior

Benefits associated with refusal of services include:

- little effort need be expended by the patient or family
- problematic mood or behavior may remit on its own

I am willing to explore alternate treatment options with you, including those provided by other agencies. If you choose to refuse services, I will work with you and your child to facilitate a referral elsewhere.

Meetings: I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. You will be charged the full fee for sessions cancelled with less than 48-hour notice, for other than the most serious reasons. This is not reimbursable through insurance.

An appointment is a commitment to work, and is an agreement to meet here and to be on time. If you are late, you will probably be unable to meet for the full time.

Professional Fees, Billing and Payments: Services are to be provided for a fee of \$120 per 45-minute session, \$150 for the initial intake session. Psychological testing is provided at \$200 per hour, which covers time for scoring, studying test results and writing the report. Fees for additional services such as extended sessions, telephone consultations, home visits, hospital visits, and attendance at meetings with other professionals you have authorized will be discussed in advance. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time.

You will be expected to pay your co-pay or deductible for each session at the time it is held. You will be responsible for paying the entire fee if your insurance fails to authorize units of service or if none are available to you, or if your medical insurance plan pays benefits directly to you. Payment schedules for other professional services will be agreed to when they are requested.

I will assume this agreed-upon fee-paying relationship will continue as long as I provide services to you. I will assume this until you tell me in person, by telephone, or by mail that you wish to end it. You have a responsibility to pay for any services you receive before you end the relationship.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Cancellations: Appointments are most often scheduled well in advance because each patient is given regular appointments. Whenever you might need to request a change in your appointment, please call at least 48 hours in advance of your scheduled appointment time. Due to the difficulty in trying to reschedule another patient on very short notice, patients will be charged for a missed appointment or an appointment not cancelled 48 hours in advance. Unfortunately, insurance will not cover missed sessions so the entire fee will be assessed to the patient, and should be paid at the following session.

Contacting Me: I am often not immediately available by telephone. When I am unavailable, my telephone is answered by secure voice mail that is monitored only by me. I will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Professional Records: The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests, and for the duplication of records.

If your records need to be seen by another professional, or anyone else, it will be discussed with you. If you agree to share these records, you will need to sign a release form. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. You may read this form at any time.

It is office policy to destroy patients' records 15 years after the end of our therapy. Until then, your case records will be kept in a safe place.

If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I will ask you to agree to transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

In the case of family or couple therapy (where there is more than one patient), and you want to have records of this therapy sent to anyone, all of the adults present will have to sign a release.

Minors: If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Confidentiality: Your participation in psychotherapy, testing, and consultation as well as the matters discussed are privileged and confidential. I am obligated by law and by ethical standards to not speak about, nor notify anyone of your participation in therapy/testing/consultation without prior permission. However, there are certain circumstances that require or allow me to breach confidentiality. These exceptions under Ohio State Law include:

- When a patient is a danger to self or others
- Incidents of suspected child/elder/disabled adult abuse or neglect
- Certain court mandated orders

More information about confidentiality is included in my Notice of Privacy Practices, which I will also supply to you. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Agreement

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

I hereby authorize Chris Kaepner, Ph.D. to provide treatment and/or other mental health services to the above named patient.

_____	_____	_____
Patient or Parent/Guardian	Relationship	Date

I refuse to authorize Chris Kaepner, Ph.D. to provide treatment and/or other mental health services for the above named patient.

_____	_____	_____
Parent or Parent/Guardian	Relationship	Date