Kops Counseling

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and Kristina Kops, Psy.D. When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here: _____.

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send to others as noted above. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I cannot treat you.

In the future I may change how we use and share your information and so may change our Notice of Privacy Practices. If I do change anything, you can get a copy by calling me at 203-226-6548.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signature of client or his/her personal representative	Date
Printed name of client or personal representative	Relationship to the client
Description of personal representative's authority	

(203) 226-6548 • kristi@kopscounseling.com • kopscounseling.com 11 Pamela Place • Westport, CT 06880

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INFORMED CONSENT FOR PSYCHOLOGICAL EVALUATION

I, _____, have been informed by Dr. Kristina Kops of the purpose of this evaluation, namely an assessment of my psychological functioning regarding: _____. I understand that the information I provide during this evaluation is confidential and will not be released to anyone else without my express written authorization. The only exceptions to this statement of confidentiality include the following: if I report I intend to harm myself or someone else, or if I report instances of child abuse or elder abuse. By signing below, I am indicating that I have had the purpose of this evaluation and any limitations regarding confidentiality explained to my satisfaction, that I have been given a chance to ask any questions I might have, and that I agree to participate in this evaluation.

_____ _____

Signature Date

_____ _____

Signature Date

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and office policies. Please read the information below carefully and ask questions about items you may not understand. Once you sign this document, it is a binding agreement between us.

Benefits and Emotional Risks:
The majority of people who obtain behavioral health services benefit from the process. The therapeutic process is generally useful to people, however, there are some risks. Some people experience uncomfortable feelings such as sadness, anger, guilt, or frustration. Also, therapy can involve a discussion of unpleasant events and situations in your life. Many people experience a reduction in discomfort over time, as well as improved relationships and better problem solving abilities. However, there are no guarantees about what your specific therapeutic experience will be. You are encouraged to ask any questions you may have about your treatment throughout the course of therapy.

Confidentiality:
A patient's confidentiality is a legal right and of significant importance to me. In most circumstances, your confidentiality is strictly maintained. However, there are certain situations in which I am required by law to break confidentiality. Such situations are as follows: 1) I believe you are a danger to yourself; 2) I believe you are a danger to another person; 3) A case of child abuse, elder abuse, or other disabled person being abused or has been abused in the past.

Additionally, if you are a minor (under 18 years of age) any information shared with me that is dangerous, or places you in risk of future danger must be discussed with your legal guardian. This will be discussed in our first session.

In the case of divorce with joint legal custody, consent forms must be completed by both parents.

Payment:
My practice is a Fee-for-Service business, which means **I do not accept insurance** as a form of payment for services. Instead the patient is responsible for the bill. While most insurance policies cover psychological services to some extent, coverage can vary. Please check carefully to determine the exact nature of your coverage if you plan to submit for reimbursement. If your coverage limits the number of sessions, please keep track of your visits and let me know when you are running low. Often, additional visits can be approved but must be done before your coverage runs out. You are responsible for payment regardless of insurance coverage.

Payment is expected for initial consultation at the time of the appointment. Following the initial visit, payment is expected at each session unless otherwise arranged. An invoice acceptable to most insurance companies can be provided for reimbursement. If at any time financially difficulties present a problem in keeping your account current, please discuss the issue with me as soon as possible.

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Cancellation Policy:
If you must cancel an appointment, please give a **minimum of 24 hour advance notice**. If you cancel an appointment without giving at least 24 hour notice, you will be charged the usual rate for the appointment. The office is open unless otherwise notified. Appointments on school and national holidays must be cancelled 24 hours in advance.

Contacting Me:
Please contact me by telephone. I do not use e-mail as a means of communication. If I am not immediately available, please leave a message on the voice mail system. I am the only person with access to the voice mail so you may leave a detailed message and your privacy will be maintained. I will return messages left on my voice mail as soon as possible, but almost always within 24 hours. On Fridays, I am either in testing sessions or out of the office, and may not return non-emergency calls until Monday. **In cases of life threatening emergency or psychiatric emergency, please call 911 or go to the nearest emergency room.**

Please reserve phone calls for scheduling issues and short matters. It is difficult to give proper attention to significant topics while on the phone. If possible, reserve these topics for your session.

Agreement:
By signing this Service Contract, you agree you have reviewed this information and agree to these conditions.

Signature of Patient / Legal Guardian

Date

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