Kristin A. Wright, Ph.D., LMFT

CLIENT ORIENTATION AND GENERAL CONSENT

I look forward to the opportunity of working with you. The following details many of the policies and procedures that are part of my practice. Please review this document and feel free to ask any questions that might arise, now or in the future.

Anticipation of the Therapeutic Process: As a client you can expect me:

- to listen to your concerns in a confidential setting as described below.
- to be knowledgeable and skilled in the application of therapeutic strategies.
- to provide appropriate referrals if necessary to other individuals, groups, or agencies.
- to be an active participant in therapy.

Common Experiences in Counseling:

Many times attending therapy is a step toward enhancing your life and your relationships—your relationship with yourself, with others, or both. Initially, the therapeutic process might be emotionally painful and cause feelings of anxiety, frustration, or depression, as your concerns are being thoroughly discussed and explored. This is an expected part of therapy, and is not an indication of lack of progress. Seeking to resolve issues between family members, partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended. Again, feel free to discuss any/all of these issues with me.

Client Rights

Therapy is most effective when it is viewed as a partnership in which each person has certain rights and responsibilities. This information will help inform you of your rights. You have the right to:

- courteous, competent, and respectful care in a safe setting.
- refuse to answer any questions or disclose any information you choose not to reveal.
- inspect and obtain a copy of your record (unless therapist determines that a release of your records would be harmful to you, or unless limited by law or a court order).
- participate in the development and implementation of your treatment plan.
- receive from your therapist information necessary to give informed consent prior to the start of therapy.
- request and receive full information about your counselor's professional capabilities and training.
- refuse treatment to the extent permitted by law, and to be informed of the consequences of such a refusal.
- approve or refuse the release of confidential information within the legal and ethical constraints of the counseling profession.

Emergency Procedures: If you or a family member are having an emergency, such as feeling like you may hurt yourself or another person, please call 9-1-1 or go to the nearest emergency room for an immediate psychiatric evaluation.

Office Hours & Phone Contact With a Therapist: Office hours are subject to change and typically change at two different times during the year. If you need to contact Dr. Wright, please call her at 314-246-9444. If Dr. Wright is not available to take your call, a confidential voice mail is available to leave a message. Please specify a phone number for Dr. Wright to reach you at and inform her if there are any concerns leaving a message at that number. Also, if you can leave possible times when you might be available, "phone tag" might be avoided. If you do not leave a phone number on your voicemail, it may take longer for Dr. Wright to return your phone call.

Confidentiality: The privacy of your therapy consultation is considered to be of the utmost importance to Dr. Wright. Your relationship with Dr. Wright and information in your case file will be kept private and confidential. Dr. Wright views consultation as an important part of sound therapeutic practice. She is involved in a consultation group with two other therapists and may share information about your case within this group. Your information will be de-identified before it is shared, and the therapists Dr. Wright consults with are all bound by the same rules of confidentiality. An exception will be made if there is a dual relationship as defined by the American Association of Marriage and Family Therapy Code of Ethics. As a client, you may also ask that Dr. Wright not consult with her consultation group. This request must be in writing.

There are times when information must and /or should be shared with others outside of the practice. In some of these instances, a written release from you as the client(s) is not necessary. In situations where a written consent is necessary and there are multiple clients who are part of therapy (e.g., couple, family group), all clients will need to sign a written consent for the therapist to release confidential information.

Legal and Ethical Issues – Missouri State Law *requires* all therapists to report any suspected or past cases of child or elder abuse to the Division of Family Services. In addition, whenever a therapist has concerns you may present a danger to yourself or others, legal and ethical standards require steps be taken to ensure the safety of those in danger. Most of the time, this can be done within the privacy of the therapy office. However, there are occasions when your family, your doctor, hospital, the potential victim, or even the police must be notified. Finally, if a court of law issues a legitimate court order (signed by a judge), we are required by law to provide the information specifically described in that order. Your written consent is not necessary in these situations.

Physician Collaboration – Communication between your therapist and your physician may be necessary for continuity of care. This communication is at the permission of you, the client, and a signed consent form must be on-file.

* **Email and Texting** – Dr. Wright has an email account associated with her practice: drkristinwright@gmail.com; however, e-mailing is only for scheduling appointment times or for billing. Likewise, Dr. Wright does text; however, it is not a confidential form of communication, and Dr. Wright does not have control over who can access content included in text messages. In addition, she is limited in her ability to confirm whom she is talking to via text. If you choose to communicate with her via texts, you are assuming the risk that those communications are no longer confidential. In addition, Dr. Wright will only respond to texts and/or e-mails to schedule appointments. Clinical issues will need to be dealt with via telephone or in-person.

Client Responsibility Regarding Confidentiality – Please do not reveal any information about any client or other visitor you may see or meet while waiting to meet with Dr. Wright or when exiting your appointments. This will help protect the privacy and confidentiality of all clients and their families.

Fees and Payment:

A full session is 50 minutes. The fee for the first therapy session is $140.00. Follow-up therapy sessions are $100.00 each. Payment must be made at the time of service, via cash, check, or credit card. Checks are made payable to *Kristin A. Wright.*

Dr. Wright is happy to provide a receipt for all services rendered, however, it must be requested. Clients may choose to submit their receipt for services to their insurance company for *out-of-network* benefit

reimbursement. Dr. Wright *does not* participate with managed care companies therefore *will not* submit insurance claims; however, is happy to help clients fill out/navigate the necessary paperwork.

Therapy on the telephone will be charged the standard fee of $100.00 per 50 minutes, $50.00 for 30 minutes, or a minimum of $30.00 for each clinical call of less than 15 minutes. Payment will be accepted by arrangement with Dr. Wright.

In the case of minor children, the parent bringing the child in for treatment will be held responsible for payment at the time of service. **THERE ARE NO EXCEPTIONS TO THIS POLICY**. If you write a check and it is returned due to insufficient funds, you will be billed a $25.00 returned check charge and Dr. Wright will not accept future checks. Future payments must be paid in cash at the time of service.

Cancelled and Missed Appointments:

An appointment is reserved for you. If you must cancel an appointment, **you must call the office and/or leave a message at least 24 hours in advance to avoid a Missed Appointment Fee**. The Missed Appointment Fee is $50.00 and you will be billed directly. The missed appointment fee is due on or before the next scheduled appointment. If you miss, reschedule, or cancel appointments to the point of not being seen for 45 days or longer, your file will be considered inactive. If you have not attended therapy in 3 months or more and/or Dr. Wright has attempted and was not able to contact you for a period of one month, your file and therapy will be considered closed. A client may resume therapy at anytime.

Telephone Contacts:

Making or changing appointments, discussing bills, etc, can be handled by leaving a message on Dr. Wright's confidential voice mail. Your call will be returned as soon as possible. For fees potentially associated with telephone contacts, see billing information above.

Preparation of Written Documents:

Preparation of reports, clinical summaries and letters **requested by you** will require a fee based on the time spent in its preparation. The minimum fee is $25.00, which is for reports taking less than 15 minutes preparation time. After the first fifteen minutes, the client will be charged $15 dollars per additional 15 minutes taken to complete the documentation. Payment is paid upon receipt of prepared documents. Parameters surrounding the release of client records can be addressed with your therapist. As noted above, when multiple clients have been treated together, all clients will need to sign a written consent for the therapist to release confidential information.

Miscellaneous Charges:

Medical Records – To cover time and cost to copy and mail, there is a Medical Records Handling Charge of $25.00 per each request to release records.

Consent:

I have read and understand the above information and agree to these policies. I understand I am responsible for all charges. I agree to receive therapeutic services from Dr. Kristin Wright, Ph.D., LMFT, and I understand that I am free to discontinue treatment at any time. I have received a copy of this document. **All parties, 18 years and older, attending therapy must sign below**.

_____ _____

Responsible Party Signature Date

_____
Printed Name and Relationship to Client

_____ _____
Client Signature Date

_____
Printed Name and Relationship to Client

_____ _____
Client Signature Date

_____
Printed Name and Relationship to Client

_____ _____
Client Signature Date

_____
Printed Name and Relationship to Client

Client Contact Information:

Name: _____

Address: _____

Phone Number:_____

Email:_____