kTherapy / Brainspotting with Katherine
45 Lyme Road, Suite 310A • Hanover, NH 03755 • 833-4-BSPKAT (833-427-7528)

INFORMED CONSENT

Client Name: _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at the office of kTherapy / Brainspotting with Katherine, hereby referred as kTherapy. The rights, risks and benefits associated with the treatment have been explained to me. I understand that therapy may be discontinued at any time by either party. kTherapy encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge. I agree to pay an hourly fee of $_____, payable at the beginning of each session.

Recipient's Rights: I certify that I have received the HIPAA agreement and certify that I have read and understand its content.

Therapy may be Discontinued Non-Voluntarily: Therapy services may be discontinued non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at kTherapy, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of discontinued services by letter or e-mail.

Client Notice of Confidentiality: The confidentiality of patient records maintained by kTherapy is protected by Federal and/or State law and regulations. kTherapy may not say to a person outside the company that a patient attends treatment or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a client either at kTherapy, against any person who works for kTherapy, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is kTherapy's duty to warn any potential victim, when a significant threat of harm has been made. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

_____

I consent to treatment and agree to abide by the above stated policies and agreements with kTherapy / Brainspotting with Katherine.

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date