

KINETIC OUTREACH & WELLNESS CENTER

Balancing the Whole Person



THERAPEUTIC SERVICE AGREEMENT

This Therapeutic Service Agreement (the “Agreement” or “Service Agreement”) states the terms and conditions that govern the service agreement between your provider, Kinetic Outreach & Wellness Center and the “Client”, who agrees to be bound by this Agreement.

CONFIDENTIALITY/PROTECTED HEALTH INFORMATION

Confidentiality means that your provider has a responsibility to safeguard information obtained during therapeutic services. All identifying information about your assessment and treatment is kept confidential, **except as mandated by law**. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during **therapy** to other persons or agencies without your consent. In such situations your provider is not required to inform you of such actions. Please note the following exceptions to confidentiality:

- Confidentiality *does not apply* to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality *does not apply* to cases of potential harm to self or others.
- A mental health professional *may disclose* confidential information in proceedings brought by a client against a professional.
- Confidentiality *does not apply* to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality *may not apply* in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality *may not apply* to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator, or guardian of a minor, **with** or **without** the minor's consent, of the treatment needed by or given to the minor.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

During assessment, evaluation, diagnosing, treating, or referring you to other providers, your provider will be collecting what the law calls "protected health information" (**PHI**). This information is needed to decide what treatment is best for you and to provide this treatment to you. The provided information may be used with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government

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functions. Any information provided during services or reports requested to be shared with other agencies or providers require a signed release of information by the client and/or legal guardian.

By signing this form, you are agreeing to have your PHI used here and to send it to others for the purposes described above. Your authorization includes the release of medical or other information necessary to process claims related to your treatment and to pay any benefits according to the assignment listed on those claims, and for payments of benefits to be made directly to your provider. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how your provider can use and share your information. If you do not sign this form agreeing to privacy practices, your provider cannot treat you, because your PHI is needed to evaluate, diagnose, and treat you.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Your provider is required by law to protect the privacy of your health information. Although your counseling record is the physical property of your provider, the information contained in your health record belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Inspect and obtain a copy of your health record
- Amend your health record as provided by regulation
- Obtain an accounting of disclosures of your health information as provided by law
- Request communications of your health care information by alternative means or locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

BENEFITS OF THERAPY

One major benefit gained from participating in therapy is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family, and other interpersonal relationships, and/or a greater understanding of personal goals and values. Additionally, formal diagnoses can be helpful for receiving the appropriate and/or necessary treatment(s), as well as identifying resources to aid in support given the presenting condition.

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RISKS OF THERAPY

You may experience a variety of negative emotions during therapy as you therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended.

The greatest risk of therapy may not by itself resolve your concerns. Psychotherapy is a collaborative process and the progress you make will depend upon your investment in the process. Receiving a diagnosis may be perceived as a "label" and possibly create some negative experiences, both internal and external. Diagnoses are based on the presenting symptoms, history, and behaviors at the time of the evaluation and could change over time.

Although your provider will maintain confidentiality, *group therapy* may pose some risk, to include, but may not be limited to, the disclosure of personal and/or confidential information addressed amongst yourself and group members while in group. It is the sole discretion of the "group member/client" to fraternize with another "group member/client" outside of the group, although prohibited.

Kinetic Outreach & Wellness Center and the "Provider" will not be held responsible for any risk obtained during individual, group, or family counseling.

Please initial to certify you have read and understood the risk and will not hold the "Provider" and Kinetic Outreach & Wellness Center accountable for associated risks. _____

PAYMENT OF FEES

All fees are to be paid at or prior to service start date and time. Cash, personal check, Zelle, MasterCard, or Visa are welcome. In the event Client fails to pay any amount due prior to or at the scheduled time of session, the session may be canceled or group participants may not be permitted to the session. It is at the sole discretion that a provider may allow a participant or the "Client" to partake in the counseling appointment.

Please note, all future sessions will be on hold or canceled until payment has been received for the prior session. Please also note, if payments are not received within 60-days of default, you will be subject to collections. Payment plans are available upon request. Communication regarding inability to pay for service is important, as you and your provider can come to an appropriate agreement to reduce a lapse in treatment.

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CANCELLATIONS

Cancellations must be made **48- hours in advance** to avoid a charge. *Late cancellations and No Call-No Show appointments will be charged a flat rate of \$50.00.* Your provider will make every effort to reschedule sessions canceled in a timely manner.

TERMINATION OF SERVICES

Either party may terminate this Agreement immediately upon notice. Notwithstanding the foregoing, “Client” shall not be relieved of any obligations to pay fees that are due solely because of the termination of this Agreement.

COMMENCEMENT OF AGREEMENT

The commencement of this Service Agreement constitutes the entire agreement between the “Client”, the “Provider”, and Kinetic Outreach & Wellness Center. The “Provider” and Kinetic Outreach & Wellness Center shall not be held responsible and shall remain blameless for any adverse or other consequences, including but not limited to financial, personal, employment, or other losses, arising out of decisions or actions the “Client” may make as a result of the services provided by the “Provider” and/or Kinetic Outreach & Wellness Center. **Your signature constitutes that you have read and accepted this agreement in its entirety.**

Client or Legal Guardian Print

Date

Client or Legal Guardian Signature

Date

Provider Signature

Date