Kimberly Yost, JD, LPC-MHSP

424 Church Street Suite 2000, Nashville, TN 37219 | (615) 638 4670 | kim@kimyost.com | www.kimyost.com

CONTRACT FOR SERVICES

Following is the contract for services between Provider, Kimberly Yost, LCPC, JD (Clinician), and Client. This contract is dated ______/_______/__________, and will remain in effect until both parties agree to written changes.

1. **CREDENTIALS**: Clinician is a Licensed Clinical Professional Counselor in the State of Tennessee (License No. LPC3944 expires 08/31/2019). Clinician is committed to providing professional mental healthcare to Client.

2. **TREATMENT**: Participation in therapy can result in a number of benefits to you, including resolution of the specific concerns that led you to seek therapy and improving interpersonal relationships. Working toward these benefits, however, requires effort on your part. There is no guarantee that psychotherapy will yield positive or intended results and it is normal to experience some unpleasant feelings from therapy. Psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors and give you more rewarding interpersonal relationships. Our collaboration in addressing your problems will be enhanced by the amount of time and effort you devote to our work outside of our therapy sessions as well as during our appointment. During our sessions, it is important that you be forthcoming about how you are feeling regarding our work, so that we can decide together if changes in your treatment should be made. I use a variety of treatment modalities, such as insight-oriented, behavioral, cognitive, mindfulness, and psycho-educational therapies, to fit your special needs. The first few sessions are often used for assessment of your situation and clarification of problem areas. Your compliance with the treatment plan, including consistently attending sessions and actively working on your issues between sessions, will increase the effectiveness of the therapy.

3. **APPOINTMENTS**: Each session lasts 50 minutes for individual appointments 80 minutes intake appointments, or 80 minutes for couples' sessions, unless otherwise specified.

4. **FEES**: Clients are expected to pay the fee of $150.00 for 50-minute individual sessions and $225.00 for 80 minutes intake appointments or 80 minute couples sessions. Payment will be due at the end of each session by cash, check, or credit card. You will be held responsible for any missed payments.

If payment is not received for services within 30 days, I have the right to refuse treatment to you and will refer you to another provider. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I may use legal or other means (courts, collection agencies, etc.) to obtain payment. No charges will be assessed for brief or occasional telephone calls. However, if there are frequent telephone calls lasting more than 10 minutes, client will be billed proportionately. Returned checks will

result in a $36.00 additional fee. Outstanding payments that are not received within 60 days will be charged a $25 late fee. I do not accept insurance. If requested, I will provide you with a copy of your billing statement, which you can then submit to your insurance company for reimbursement if you so choose. Fees may change in the future and Client will be notified in writing at least 30 days prior to any fee change.

5. **CANCELLATION POLICY**: If you do not cancel your appointment at least 24 hours in advance, you will be charged in full for that session. You may leave me a message on my voicemail at (410) 804-5543 or email me at kim@kimyost.com.

6. **TERMINATION**: You have the right to terminate participation in therapy at any time, for any reason, and without any penalty. However, it is important to discuss any desire to terminate with me in advance to provide closure, which is an important part of the therapy process.

7. **LITIGATION LIMITATION**: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

8. **COMMUNICATION WITH ME**: If you communicate with me via email, telephone, text message, or HIPAA compliant telemedicine software VSEE, I will assume that you have made an informed decision to do so, and will view it as your agreement to take the risk that such communication might be intercepted, read, viewed, or listened to by a third party. Unless you indicate otherwise, I may use the email address you provide to communicate with you about your appointments. If you need to contact me between sessions, please leave a message on my office voicemail, (410) 804-5543, and your call will be returned as soon as possible.

9. **CONFIDENTIALITY**: Clinician will adhere to the HIPAA rules and regulations. While excluding any of your identifying information, Clinician may discuss your case without your written consent with colleagues. Clinician is mandated by the state of Maryland to report if she has reason to suspect any case of abuse of a minor, elder, or individual with an intellectual or physical disability, or if there is imminent threat of harm to yourself or other(s).

10. **EMERGENCY PROCEDURES**: **If you have a mental health or medical emergency, please call 911 or go to your nearest emergency room**. If you need to talk to someone right away, call:

- Suicide and crisis hotline for Howard County: (410) 531-6677
- Suicide and crisis hotline for Baltimore: (410) 576-5097

- Suicide and crisis hotline for Washington Metropolitan area: (202) 527-4077

11. **CONSENT TO TREATMENT**:

I have read the above policies and have read my rights.
I do hereby seek and consent to take part in therapeutic services.
I understand that no promises have been made to me as to the results of treatment.
I am aware that I may suspend or terminate my treatment at any time.

By my signature, I am affirming that I understand and accept the policy described in this document and that I have received copies of the HIPAA form. By agreeing to psychotherapeutic treatment, I understand that services will be rendered in a professional manner, consistent with accepted ethical and HIPAA standards.

____ ____________________

Client Signature **Date**

____ ____________________

Guardian Signature (if Client is under 18) **Date**

If Client is under eighteen years of age, responsible Guardian agrees to all terms and conditions of contract and is legally bound by the same terms as Client.

____

Guardian's Name

Kimberly Yost, LCPC, JD

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CREDIT CARD INFORMATION

Please provide credit card information below. Your credit card information will be held on file in the event that (1) you have not brought adequate payment to your appointment at time of service, (2) in the event that your check is returned for insufficient funds in the account + a$36.00 return item fee, (3) there is a no show or a cancellation without 24 hour notice of cancellation, or (4) there is need for supplemental professional services (i.e., extended reports, inter-disciplinary meetings, court appearances) that have been discussed with you in advance. Submitting this form authorizes the billing of your credit card for purposes described until such time as all balances are cleared and your active client record is closed with Kimberly Yost.

Client Name: ____

Credit Card Number: ____

Expiration Date: _______________________ CVV: ______________

Billing Zip Code: ______________________

By my signature, I am affirming that I understand and accept the policy described in this document and that I have received copies of the Notice of Privacy Practices. By agreeing to psychotherapeutic treatment, I understand that services will be rendered in a professional manner, consistent with accepted ethical standards.

____ ____________________

Client Signature

Date

____ ____________________

Guardian Signature (if Client is under 18) Date

If Client is under eighteen years of age, responsible Guardian agrees to all terms and conditions of contract and is legally bound by the same terms as Client.

____

Guardian Name

Kimberly Yost, LCPC, JD

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AUTHORIZATION FOR PHYSICIAN DISCLOSURE/RELEASE OF INFORMATION

In order to best serve you, it is my standard practice to contact the primary care physician or treating physician of all new clients. Many times this is simply a professional courtesy and away to establish coordination of care, if needed, now or in the future. This usually consists of a fax and brief phone call to let your physician know that you are engaged in my counseling support. I do not share details of your treatment that are not relevant to your physician. I am also willing to send a letter of introduction to physicians should I refer you for a medication consultation. To assist me in this, please provide the following information:

Patient Name: ____

Patient Address: ____

____

Patient Date of Birth: _________________________________

Patient/Guardian/Surrogate Parent Name : (if applicable) ________________________________

I give my permission for the following individual or agency to obtain and/or release the protected information checked below about me or my child for use in my therapeutic treatment efforts. I understand this information will be private and that my permission is voluntary. At any time, I can revoke this permission by notifying Kimberly Yost in writing. I understand that a revocation will not be retroactive and will not affect disclosures prior to revocation. I understand the information to be released may contain details about any of the conditions/issues for which I am being treated or may be restricted only to generic disclosure about my engagement in counseling, as indicated below. I understand that this information may include medically sensitive material, and I authorize its release for the purposes stated. I understand that information used or disclosed related to this authorization may be subject to redisclosure by the recipient (my doctor) for therapeutic purposes and is subject to the

privacy rules of the recipient. I understand I may restrict the release of my information based on my reply below. I understand this information is being obtained for purposes of therapeutic benefit and/or planning.

____ ___________________

Your Signature **Date**

PLEASE CHECK ONLY ONE:

☐ I authorize Kimberly Yost to release my information containing details about the conditions and issues for which I am engaged in counseling.

☐ I do NOT authorize release of specific information about my counseling treatment. You may only disclose my diagnosis and that I am a client.

Your Doctor's Name: ____

Name of Practice:____

Address of Practice:____

City: ______________________________________**State:** ________ **Zip:** __________________