Victoria Whitetree, LSCSW
123 N. Tyler Road, Suite 300
Wichita, Kansas 67212
Phone 316.869.2225 Fax 316.869.2221

Welcome. This form was developed in order to introduce myself and to inform you of my policies and procedures. After reading, please feel free to ask any questions you may have.

CONFIDENTIALITY

Typically, information shared with a therapist is protected and cannot be shared with anyone else. In most circumstances I require a written release of information before disclosing any information to a third party. However, I may be required by law to provide information in order to protect another person, protect a client from harming themselves, or to report suspected child abuse. If there is a threat to hurt another person I have a "duty to warn" the person(s) and notify the authorities. I may also need to release information if emergency treatment becomes necessary. Clients will be informed if I must report information to a third party. Court ordered release of records are rare, but do occur. I will make every effort to protect a client's confidentiality and I will notify clients of any disclosure.

You have a right, in most instances, to review your records. I request that we review information together so that I may explain clinical language.

In cases where a minor is my client, parents/guardians are entitled to information regarding the child's treatment. I will provide parents/guardians with information about the treatment plan, progress toward goals, and what the parent/guardian can do to assist. If the minor is engaging in activity that will be harmful to themselves or others, the client and myself (if appropriate) will decide how to best notify the parent/guardian.

If there is a breach of unsecured protected health information concerning you, we may be required to notify you, including what you can do to protect yourself. I will not sell protected health information. For information related to e-mail confidentiality, please refer to the e-mail consent form. Other forms/procedures may be needed in the future and clients will be notified at that time of requirements.

FINANCIAL AGREEMENT

Intake	$175.00
50 Minute Therapy Session	$125.00

The intake session is billed at a higher rate in order to account for the initial paperwork to be completed and entered. Co-pays are due at the time of service. Account balances must be current in order to continue scheduling. I reserve the right to utilize a collection agency in the event balances are left unpaid.

Twenty-four hour notice is required on all cancellations in order to avoid a charge. Appointments missed without proper notification are subject to the following charges and may result in the cessation of services. No show fees are to be paid before the next scheduled appointment. Please note: Insurance companies do not pay for missed appointments.

1st Incident – $25.00 at clinician discretion
2nd Incident – $125.00 fee is charged and treatment services are subject to termination

I accept most major insurance plans. It is the client's responsibility to contact their insurance company in order to assess the need for a referral from the primary care physician, obtain coverage benefits, deductibles, and co-pays. We are happy to bill your insurance carrier if provided with the necessary paperwork. Please note that other services, except those involving direct contact with a client, may not be

covered by insurance. These include report writing, attendance at meetings, and consultation with family members. Insurance companies may require that I provide them with information regarding current concerns, treatment plans, and interventions utilized. A diagnosis is always required. Please be aware that insurance companies do not cover services if a client does not meet criteria for a psychiatric diagnosis. I may not disclose information about care the client has paid for out-of-pocket to health plans unless it is for treatment purposes or in the rare event the disclosure is required by law. If you have questions about your diagnosis, or any other information and how it will be used, please don't hesitate to ask

Due to schedule restrictions, I may not often be able to answer my phone. My telephone does have voicemail access day and night which I monitor regularly.

CONSULTATION

Effective clinicians continue to learn throughout their career. Part of the learning process includes consulting with other clinicians. Only the most general of information is given in order to ensure confidentiality. Those clinicians with whom I consult are bound legally and ethically by the same rules of confidentiality as I.

Physician Consultation:
In Kansas, licensed mental health professionals are required to consult with a client's primary care physician or psychiatrist whenever symptoms of a mental health diagnosis are present. The purpose of such consultation is to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms. The client/parent/ legal guardian may also choose to waive such consultation. The clinician may provide treatment or evaluation until such time that the medical consultation is obtained or waived. I have been informed of the recommendation to seek medical consultation.

Physician Name _____ Address _____

Phone # _____

accepted _____ waived _____
(consent to release information must be signed)

_____ _____
Signature of Client/Parent/Legal Guardian **Relationship**

Thank you for choosing to share this important part of your life and I look forward to working with you.

Victoria Whitetree holds a Master's Degree in social work. Beyond that she is licensed as a Licensed Specialist Clinical Social Worker (LSCSW).

By my signature I acknowledge that I have received or been given an opportunity to read a copy of Victoria Whitetree, LSCSW, LLC's Notice of Privacy Practices. I understand if I have questions regarding my privacy rights I can contact Victoria Whitetree, LSCSW, LLC at 316-869-2224.

My signature indicates I have read and understand the information and agree to the policies as stated.

_____ _____
Client/Parent/Guardian Signature Date