Leslie C. Kilpatrick, M.Ed., LCSW, LLC
P.O.Box 204
Oakton, VA 22124
(703) 691-3578
www.leslieckilpatrick.com

CONFIDENTIALITY STATEMENT/THERAPEUTIC RELATIONSHIP POLICIES/ CONSENT TO TREATMENT

As a general rule, I will disclose no information obtained from your contacts with me, or the fact that you are my client, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law.

1. It is my policy to provide information to others without your consent, in certain circumstances:

a) HARM TO SELF: If I believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for insuring your safety of the safety of others.

b) VACATIONS/EMERGENCIES: When I am on vacation or away from the office for extended periods of time, a colleague may cover for my practice and take emergency calls. If s/he will need information in order to assist you in my absence, I will provide it without using your full name; you and I will discuss the plan first.

c) CONSULTATION: To ensure that I am providing quality care, I meet regularly with a peer consultation group. I do not reveal identifying information. I will provide the names of my peer consultants upon request.

2. **Virginia law requires psychologists to release information to others in certain circumstances**:

a) Virginia therapists are required by law to report certain information:

(1) Suspicion of abuse or neglect of a child or of an aged or incapacitated adult must be Reported to the Department of Social Services

(2) Information that a Psychologist is engaging in unethical or illegal practice must be reported to the Board of Psychology.

(3) If you are licensed by a Health Regulatory Board, I am required to report that you are receiving therapy if I believe that your condition places the public at risk.

b) Virginia law imposes upon therapists the legal duty to protect other members of society from harmful actions by their clients. Voiced threat of direct harm to another person can result in notification of the potential victim, law enforcement officers, and/or others as specified by statute.

c) In Virginia court cases, therapist-client privilege may not apply in certain cases, including the following:

(1) Criminal cases

(2) Child abuse cases

(3) any court case where your mental health is an issue, and/or

(4) any case in which the judge "in the exercise of sound discretion, deems it necessary to the proper administration of justice." This means that information communicated to a therapist can be admitted as evidence in a court case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either treatment records or testimony from you present or former therapist as evidence in a court case (including child custody cases). If I receive such a subpoena, I will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash a subpoena and requesting that the confidentiality of the therapy relationship be protected. However, only the judge may decide whether or not the requested information may be disclosed.

d) Virginia law allows certain others to request access to treatment records in specific circumstances. These include:
(1) Protective Services Workers to whom I have reported suspicion of abuse or neglect, if they so request;
(2) Court-Appointed Special Advocates in child abuse or neglect proceedings, if the court so orders; and
(3) Evaluators for minors' Involuntary commitment to inpatient treatment, if they so request. In such cases, I will make every effort to attempt to limit the information disclosed by substituting an oral or written report rather than submit actual treatment records.

3. Information will be provided to Third Party Payers only with your consent:
If you wish to obtain third party reimbursement for mental health services, or to use in-network benefits, certain information must be provided. You must decide whether to give consent to me to release the necessary information to an insurance company (or other third party payer) in order to use your benefits or receive reimbursement. Initially, that usually involves providing information about dates of treatment, type of treatment, and nature of your problem (diagnosis). If I receive requests for further information, these will be discussed with you before the information is provided.

THERAPEUTIC RELATIONSHIP POLICIES

Discontinuing Services: Ending treatment is an important part of the therapeutic process. Please discuss with me any desire or plan to discontinue therapy so that it may be worked into the therapeutic process. By signing this form, client agrees to schedule a termination session prior to discontinuing treatment. This session will include any referrals for continued treatment or other professional services as necessary. Please initial that you acknowledge this: _____ Date _____

Recording devices: Sessions may not be recorded in any manner except in extremely rare cases with clinician's prior approval and written permission, which will go into the client file. Recording sessions compromises confidentiality, and may present safety concerns in some cases. Please initial that you will not knowingly record sessions in any manner: _____ Date _____

Social Media Interaction: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) I believe that adding clients as friends or contacts can compromise confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. Regarding a Facebook associated with Leslie C. Kilpatrick, LLC in particular, please do not "check in," give reviews/stars, comment, post or "like" because other consumers of Facebook can view these actions and make inferences about our relationship that could compromise your confidentiality. Please initial that you acknowledge all of this:
_____ Date _____

DOCUMENTATION OF CLIENT AUTHORIZATION

I understand that if I receive mental health services from Leslie C. Kilpatrick, the above limitations may be imposed on confidentiality. I hereby accept those limits of confidentiality and consent to receive services under those conditions.

I do☐ do not☐ give permission/consent for claims/forms/treatment plans to be submitted for third party reimbursement if this information is requested.

CLIENT SIGNATURE: _____
(Parent if client is a minor)

Date: _____

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FINANCIAL AGREEMENT

Please acknowledge the financial policies by initialing each item below:

_____ Billable services include, but are not limited to clinical interviews, psychotherapy, telephone consultations, report production, school consultations, testimony, travel time, missed appointments and other professional fees.

_____ Missed appointments, and those not cancelled with twenty-four hours of notice, will be billed at the full psychotherapy rate.

_____ Out-of-Network and Co-Insurance payments are due at the time service is rendered.

_____ Final payment is due within thirty days of balance notification by this office.

_____ Checks are payable to Leslie C. Kilpatrick, LLC. ***Please prepare payments prior to your appointment; this will allow more time to focus on therapeutic topics rather than administrative matters.***

_____ Client is responsible for any fees incurred in the collection of payment, including attorney's fees.

_____ Services rendered by Leslie C. Kilpatrick, M.Ed., LCSW, LLC are billed according to the following fee schedule:

Individual Psychotherapy	50 minutes	$180.00
Parent/Family Psychotherapy	50 minutes	$180.00
Process Group (per client)	75 minutes	$125.00
Brief Phone Consultation	< 30 minutes	$90.00
Full Phone Consultation	> 30 minutes	$180.00
School Meetings (including travel time)	Per hour	$180.00
Court Testimony, Deposition, Meetings	Per hour	$400.00

_____ _____

Client or guardian signature Date