

## KATHRYN H. HEDICAN LMHC, RPT, LLC

### INFORMED CONSENT

Thank you for choosing Kathryn H. Hedican LMHC, RPT, LLC to provide counseling for you and your family. Today and future appointments will take approximately 50--60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. I have earned a Bachelor of Arts Degree in Psychology and a Masters Degree in Mental Health Counseling from the University of Northern Iowa. I am licensed by the State of Iowa as a Licensed Mental Health Counselor and am credentialed as a Registered Play Therapist. I have over five years of clinical experience in treating children, adults and families using individual and family therapy. I also have advanced training in both Adlerian Play Therapy and in EMDR (Eye Movement Desensitization Reprocessing), a well researched intervention to treat those who have endured trauma. I practice standard cognitive behavioral therapy for most conditions. Although other theoretical treatment approaches are used depending on the person or condition. Treatment practice and philosophy will be discussed with you today.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** Your verbal communication and clinical records are strictly confidential except for: a) information shared with a psychiatrist or your primary care physician, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Iowa State Law, I am obligated to report this to the Department of Human Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Kathryn H. Hedican will follow those emergency services with standard counseling and support to the client or the client's family.

**Signature(s)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FINANCIAL/INSURANCE ISSUES:** As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If

your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds \$300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Kathryn H. Hedican LMHC, RPT, LLC.

**CANCELLATION OR MISSED APPOINTMENTS:**

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. **You may have a copy of this form if requested.**

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

**COORDINATION OF TREATMENT:** It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.** If you prefer to decline consent no information will be shared.

\_\_\_\_ You may inform my physician    \_\_\_\_ I decline to inform my physician  
**PHYSICIAN NAME:**

\_\_\_\_\_  
**CLINIC:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:**

I/We consent that \_\_\_\_\_ maybe treated as a client by Kathryn H. Hedican. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. If the child’s parents are divorced a copy of the divorce decree is required to verify custody status.

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_