Charlotte Therapy Associates

Kate van Wagenberg MS, LMFT
5200 Park Rd, Suite 219
Charlotte, NC 28209

Professional Disclosure Statement

Overview:
I, Kate van Wagenberg, am a Marriage and Family Therapist licensed by the state of North Carolina (license number 1354). The intent of this document is to provide you with important information regarding your treatment, in addition to obtaining your consent for therapeutic services.

Description of Services:
As a licensed Marriage and Family Therapist, I help people explore and solve problems according to their individual values and lifestyles. I believe therapy is a process devoted to growth and change.

I conduct therapy in a manner that enables clients to understand present patterns, identify and remove constraints, and achieve better functioning and enhanced growth. The first few sessions will be spent getting to know you, listening, and assessing. Together, we will develop goals and objectives. You are always in control based on your desire to attend.

Sessions, Fees, Payment Method and Cancellation Policy:
The Initial Diagnostic Interview lasts 60-75 minutes unless other arrangements are made. Fee: $150

Individual Sessions (adult or adolescent) last fifty (50) minutes beginning on the hour and ending ten (10) minutes before the hour unless other arrangements are made. Fee: $120

Couple and Family Sessions last sixty (60) minutes beginning on the hour and ending on the hour unless other arrangements are made. Fee: $130

Couple and Family Sessions last eighty (80) minutes beginning on the hour and ending ten (10) minutes before the half hour unless other arrangements are made. Fee: $165

Payment of services is expected at the time of each session and a receipt will be provided. If we have made arrangements to file insurance directly you are responsible for any co-pays due and ultimately responsible for payment in full if your insurance company does not pay within 90 days for any reason. It is your responsibility to file with your insurance unless other arrangements have been made with me. If payment for services is not made at that time and it is not a matter of special arrangement agreed upon by you and me, such payment must be made within 10 working days of the session in question AND before a new appointment can be made. If payment is not made within this time period, I have the option of informing you in writing, that future services might be jeopardized and even discontinued. In this instance, I will provide you with names of other practitioners if requested.

If you fail to cancel scheduled therapy appointments at least 24 hours in advance, an automatic charge of the full session fee will be made for the missed appointment and added to your fee during the next scheduled session. Cancellations for Monday appointments need to be made before noon on the prior Saturday. There are two exceptions; if the roads are dangerous due to snow or ice or if you have a contagious disease that the therapist or others in the office might contract. If the therapist is working with you as a couple and if you come alone without your partner, the therapist will need to assess the risk versus value to your partnership of seeing only you. If the therapist determines it is not in the interest of your relationship, then you will, nonetheless, be charged for the entire session. Please understand, that insurance companies may not reimburse for charges resulting from missed appointments. If you fail to attend two consecutively scheduled sessions without notifying me, I will assume that you wish to terminate services and I will notify you in writing, that services have been terminated. Two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. You may terminate services at any time by notifying me.

If a check is returned due to insufficient funds, there will be a $50.00 charge to cover bank fees. Payment of the session fee and $50 charge must then be made at or before your next scheduled appointment. There is a $2 charge per transaction when paying for services with a credit card.

Phone Calls:
I am happy to speak with you by phone if a pre-arranged time is scheduled to do so. It is often easier to reach me and communicate with my by e-mail (my e-mail address is kate@charlottetherapyassociates.com). However, should you prefer to speak with me by phone for any reason any phone calls lasting over 10 minutes will be billed at my normal hourly rate and payment due at the next scheduled session or within 7 business days of the phone consultation, whichever comes first.

Emails:
E-mail communications requiring 15 minutes or more, between your therapist and you regarding matters of ongoing therapy will be charged in 15-minute increments $30 per 15-minutes. There is no charge for emails concerning administrative and scheduling matters.

Emergencies:
I do not provide any emergency therapeutic services. In the case of an emergency, please contact 911, or contact your primary care physician. You can also go to the local emergency room request the psychiatrist on call. Here at the numbers to two local hospitals with emergency behavioral healthcare:

Carolina's Medical Center, Randolph Rd.- 704-358-2700
Presbyterian Hospital Behavioral Health- 704-384-4255

Registering Complaints:
On occasion clients have concerns and complaints. Clients are urged to bring complaints to the therapist's attention immediately. Clients may also register complaints with the North Carolina Board of Licensed Marriage and Family Therapists, 1001 S. Marshall St., Winston-Salem, NC 27101.

Records and Confidentiality:
If your insurance company is paying in part or full for your session, they sometimes have the right to gain information regarding your counseling sessions. This varies with different insurance companies. If there is any question about this it is suggested you contact your insurance company so that you know what access they are allowed to have as part of your policy agreement. Additionally, in order to file through insurance it is required that I give you a diagnosis. It is important that you understand that not all diagnoses are covered under any given insurance plan and that when a diagnosis is given it becomes part of your records with the insurance company.

Your counseling sessions, and the discussions therein, remain confidential unless I obtain a signed release from you for me to discuss your case with another professional. Case records are confidential and will not be released without written permission from you. As your therapist I may be receiving on-going consultation from an individual who is bound by the same rules of ethics as I am. In such an instance, information will be discussed for professional purposes only and every effort will be made to protect the client's identity and information.

However, in certain circumstances it is required that confidential information is disclosed without your consent which include, but are not limited to the following: 1) If you are evaluated to be a danger to yourself or others; 2) If you are a minor, elderly or disabled and the counselor believes you are the victim of abuse or if you divulge information about such abuse; 3) If a court order or other legal proceedings or statute require disclosure; 4) Your insurance company requires information in order to pay claims; 5) As stated above, at your request.

By signing below I acknowledge that I have had the opportunity to ask any questions I may have on limits of confidentiality. I have also discussed the goals of therapy with Kate and understand that therapy is a joint effort between the counselor and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as my interactions with family, friends, and other associates.

By signing below, you are indicating that you have read and understand the information contained in this statement, that you have been given a copy of this form for your records, and that any questions you have about this statement have been answered to your satisfaction.

Consent for Treatment:

I, ___________________________________ have read the above "*Professional Disclosure Statement,*" and give my consent for treatment and have had the opportunity to ask questions.

I have also discussed the goals of therapy with Kate and understand that therapy is a joint effort between the counselor and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as my interactions with family, friends, and other associates.

Client Signature (1) ____ Date_____________

Client Signature (2) ____ Date_____________
(if applicable)

Parent/Guardian Signature ______________________________________ Date_____________
(if applicable)

Therapist Signature____ Date_____________
Kate van Wagenberg, MS, LMFT

Client Billing Agreement:

I hereby give Kate van Wagenberg, MS, LMFT, to provide counseling services to:

____ ____________________

Client Name Date of Birth

I understand that Kate van Wagenberg, MS, LMFT will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

- $150.00 Initial session (60 min)
- $120.00 Individual Therapy (50-60 min)
- $130.00 Couples or Family Therapy (60 min)
- $165.00 Couples or Family Therapy (75-90 min)
- $120.00 Consultation or Report writing (per hour)
- $120.00 Case Management (per hour)
- $120.00 Phone Calls per hour (billed after 10 min.)
- $ 2.00 Credit Card processing fee
- $ 30.00 Emails requiring 15 min. or more (billed in 15 min increments)

I understand that payment for services are expected at the conclusion of each session and that a receipt will be provided for me. If insurance arrangements have been made prior to the session and a co-pay is applicable, it is due at the time of my session. ***If for any reason your insurance does not agree to pay your fee (co-pay or percentage), you are ultimately responsible for payment in full.***

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Kate van Wagenberg, MS, LMFT for a missed or unpaid for appointment.

Credit Card #____________________________________ Exp.________________

Billing Address Zip Code: ______________ VISA MASTERCARD AMEX Security Code: _____

Your insurance company has informed me that your benefits are as follows:

Insurance Company:__________________ Deductible: __________________ Co-pay: _________

Max. # of sessions/Amount:__________________ Per Calendar Year/Benefit Period:_______

I agree to allow Kate van Wagenberg, MS, LMFT, to bill my insurance company directly for service provided and understand that the insurance company may request information in order to process payment. I give her permission to release the necessary and requested information to the insurance company.

If payment is not made at the time of my appointment and it is not a matter of special arrangement agreed upon by myself and Kate van Wagenberg, MS, LMFT, payment must be made within 7 working days of the session in question AND before a new appointment can be scheduled. If payment is not made within this time period, Kate van Wagenberg, MS, LMFT has the option of informing me, in writing, that future services might be jeopardized and even discontinued. I understand that she can provide me with names of other practitioners if requested.

If I fail to cancel a scheduled appointment at least 24 hours in advance, I understand that an *automatic* charge of the full session fee will be made for the missed appointment and added to my fee during the next scheduled session. I understand that I will be responsible for this fee as **insurance *does not* pay for missed appointments**. You can call me at 704-705-4550 ex 2 to notify me or leave a message as well as via email at kate.clttherapyassociates@gmail.com. If I fail to attend two consecutively scheduled sessions without notifying Kate, she may assume that I wish to terminate services. I also understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. I also understand that I may terminate services at any time by notifying Kate van Wagenberg, MS, LMFT.

If for any reason I am subpoenaed to testify in court on your behalf or regarding your case my fee is $200.00 per hour. This includes travel and waiting time as well as preparation time. I require a $500.00 retainer fee in advance. You will be responsible for payment of this fee in full.

I agree to the terms of the counseling and fee agreement as stated above and understand the above requirements. I release Kate van Wagenberg, MS, LMFT from liability.

Client Billing Agreement:

Client Signature (1) ____ Date_____________

Client Signature (2) ____ Date_____________
(if applicable)

Parent/Guardian Signature ______________________________________ Date_____________
(if applicable)

Therapist Signature____ Date_____________
Kate van Wagenberg, MS, LMFT

CLIENT INFORMATION SHEET

Name (1): ____

Name (2): ____

Address: ____

City: ______________________________ ST:_______ Zip:______________

Billing Address: ____

City: ______________________________ ST: _______ Zip: _____________

Phone (1): Day (______)___________________________ Eve (______)____________________

Phone (2): Day (______)___________________________ Eve (______)____________________

E-mail (1): ___________________________________ E-mail (2): ___________________________________

Date of birth: (1) ______________ Date of birth: (2) ________________

Authorization to leave a message identifying therapist's name and number? YES ________ NO ________

Referral Source: _______________________

A CONTACT PERSON IN CASE OF EMERGENCY:

Name:__________________________________ Relationship: __________________

Phone: (______) _______________________

INSURANCE INFORMATION:

Will you be using your insurance? YES ___ NO ____ Insurance company: _________________

Member ID number: ___________________ Name of insured: ________________________

DOB of insured: ____________________ Insurance phone #: ______________________

Are you or any family members in therapy now? YES _____ NO _____

Previously? If so, when, with whom, and for what reasons?

Do you want the therapist to talk with a previous therapist(s)? YES _____ NO _____

Therapist Name: ___________________________________ Phone #: ________________________

SIGNATURE for Consent: ____________________________ Date: _____________

CLIENT INFORMATION SHEET 2

FAMILY INFORMATION: Start with all family members, and nonmembers, who live in the household and then include those outside the household that may also participate in the therapy.

Family/Other Members:	Ages:	Relationship To client:	√Members present

- List any current or past history of alcohol and/or drug misuse for you and/or any family member:
- List any current or past history of any nervous and/or mental disorder for you and/or any family member:
- List any current or past history of legal difficulty or trouble with the law:
- Are you, or is anyone else in your family, experiencing thoughts of harming oneself or someone else?
- Have you or anyone in your family experienced instances of physical violence now or in the past?
- Have you had problems with any natural disasters (i.e., flood, hurricane) or other traumatic events?
- Do you have any special needs regarding therapy, such as a physical disability?

PROBLEM INFORMATION

- Briefly describe what brings you into counseling:
- Briefly describe the history and development of your concern from onset to present:
- Why are you coming for counseling now instead of a few months ago or a few months from now?
- What are your goals for counseling—what do you wish to accomplish?

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Notice of Privacy Practices
HIPPA (Health Information Portability & Accountability Act) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of you PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also, Professional Disclosure.)

Disclosure of Information
Whenever your PHI is released or obtained, it will be the minimum information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics.
These include:

- Emergencies.
- Reporting of abuse or neglect.
- Disclosures required by court order.
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Your Rights Regarding Privacy
By law, you have certain rights regarding the health information that I collect and maintain about you.
These rights include:

- The right to inspect and obtain a copy of your medical record.
- The right to request an amendment of any section of your medical record.
- The right to request restriction of disclosure of your PHI for the purposes of treatment, payment, and health care operations.
- The right to request an accounting of the disclosures that we make of your health care information.
- The right to request confidential communication.
- The right to a copy of this notice.
- The right to refuse to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights
If you have any further questions and/or concerns about this notice please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800 368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.
THIS NOTICE IS EFFECTIVE OCTOBER 1, 2011

PLEASE KEEP THIS FOR YOUR RECORDS

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: ______________________________ DOB: ___________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact Kate van Wagenberg, MS, LMFT at kate@charlottetherapyassociates.com or 704-705-4550 ex: 2.

____ _______________________
Signature of Patient Date

____ _______________________
Signature of Patient # 2 Date
(if applicable)

____ _______________
Signature or Parent, Guardian or Personal Representative Date

____
* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.).

____
Patient/Client refuses to acknowledge receipt

____ _________________
Signature of Staff Member Date

MEDICATION/PHYSICIAN SUMMARY

Client #1

Name: ____ Date: ___________

Please list any current medications (use reverse if needed):

____ purpose: ___________________ dosage: _________

____ purpose: ___________________ dosage: _________

____ purpose: ___________________ dosage: _________

____ purpose: ___________________ dosage: _________

Primary Care Physician: ____

Signature for Consent: _________________________________ Date: ________________________

Client #2

Name: ____ Date: ___________

Please list any current medications (use reverse if needed):

____ purpose: ___________________ dosage: _________

____ purpose: ___________________ dosage: _________

____ purpose: ___________________ dosage: _________

____ purpose: ___________________ dosage: _________

Primary Care Physician: ____

Signature for Consent: _________________________________ Date: _____________