Kimberly Knowlton-Young, LICSW
20 West Park, Lebanon, NH / P.O. Box 1161 Norwich, VT 05055
339-440-1103

Private Practice Policies and Consent to Treat Agreement

I. Confidentiality:

According to New Hampshire laws, information revealed during treatment is confidential and cannot be shared with anyone else without your written consent. However, there are some exceptions:

- New Hampshire laws require that if a disclosure is made regarding a child or elder abuse or neglect, a report must be made to the appropriate authorities.
- New Hampshire laws require that if a client demonstrates imminent danger to himself or herself or to another person, steps must be taken to avert that danger.
- Records may also be subject to audit by the New Hampshire Office of Professional Regulations.
- As part of my commitment to a high standard of clinical practice I do consult regularly with other professionals. In these consultations, every effort is made to disguise information that would reveal the identity of a client. Consultants are also legally bound by the rules of confidentiality.

II. Conflict of Interest:

The Upper Valley is a small area. From time to time, actual or potential conflicts of interest may arise. In the event that I become aware of a conflict of interest in providing services to you, I may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be assured that any information will remain confidential.

III. After-Hours Availability and Emergencies:

You may leave confidential messages on my private voicemail at 339-440-1103 at any time of day or night. I check messages every few hours between 8:00 am and 5:00 pm weekdays and less often on weekends. Sometimes, I will be away or it may take me a few days to respond as I work only three days a week. The voicemail should not be considered an emergency response system.

If I cannot be reached immediately in an emergency, please call 911 or go to your nearest emergency room. Please leave me a voicemail message indicating which facility you will be using.

IV. Minors

The clinical treatment of minors must be authorized by a parent or guardian (with limited exceptions). I will not undertake treatment without consent of both parents. Although communications with adult clients are confidential as described above, in the treatment of minors, parents (even non-custodial parents) have a right to access and authorize release of the information unless I deem it unsafe to the child. When a child turns 18, control of

treatment, information, and records reverts to the child. If parents participate in sessions, they may also be clients.

V. Limits of Services

Unless specified and agreed to otherwise, my role is to provide psychotherapy services, not to assess fitness of custody, serve as an advocate on other issues, or act as an expert witness.

VI. Telephone Consultations and Special Reports

Sometimes it is necessary for you to talk with me outside of session hours, or for me to contact other involved parties. Most conversations need only take 5 or 10 minutes. Time spent beyond 10 minutes may be billed as a consultation at the pro-rated hourly rate. Also preparation of reports that require information beyond the standard medical record may also be charge at a prorated fee.

VII. Financial Policies

a. Rates

My fee for a 55-minute session is $120 per hour. I will bill your insurance directly for all expenses except your co-pay. Your insurance company will reimburse based on what they determine to be usual and customary rates. I am committed to providing the best possible services and my fees are in line with area rates.

b. Payments

Co-payment is due at the time of service, or within 30 days of the statement of services. Most insurance companies will reimburse promptly. It is your responsibility to pay for all costs incurred that your insurance company declines to pay for, such as if I am not a contracted provider with your insurance company. You are not responsible to pay the difference between what your insurance reimburses and my fee. Cash and checks are accepted.

c. Missed Appointments

Keeping track of therapy appointments is an important part of the psychotherapy process. If you discover that you will be unable to attend a scheduled session please contact me within 24 hours. If it is a Monday appointment please contact be before 1:00 the Friday before. If less than 24 hours' notice is not provided you will be charged $60 for the missed session. NOTE: This does not apply to clients using Green Mountain Care. Exceptions can be made to this if we both agree that the missed appointment was unavoidable or due to an emergency, illness or dangerous driving conditions. If you are late to therapy the ending time will need to remain the same.

VIII. Professional Qualifications:

I provide professional outpatient psychotherapy to clients with a focus on adolescents, parents, and adults. These services may include an intake evaluation at your first visit as well as regular individual and/or family counseling. I am a graduate of Simmons College of Social Work and am licensed in the states of Vermont (#089.0081423) and New Hampshire (#1824).

IX. Professional Boundaries and Misconduct

Social Workers are obligated to maintain professional boundaries with current and former patients. For example, sexual relationships with current and former clients constitutes misconduct and probably represents violation of state law.

X. Compliance Procedures

I encourage you to first fully discuss any concerns you have about your services with me. If you are still unsatisfied and you believe any misconduct on my part has occurred, contact the New Hampshire Office of Professional Licensure at 603-271-2152.

XI. Electronic Communication

As a convenience to you and me, I often communicate with clients regarding treatment via electronic communications (e-mail or text message). This means that I may transmit protected health information such as information about appointments, diagnosis, medications, progress and other individually identifiable information to you via electronic communications. I try very hard to limit what is sent electronically to appointments and resources but if you feel concerned about the information, please let me know.

There are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. Health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties. **By initialing the below statement you agree that I, Kimberly Knowlton-Young, shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by myself to you.**

Please Initial and sign below:

_____ I have reviewed Ms. Knowlton-Young's Practice Policy and Consent to Treatment Agreement. I have had all my questions answered and I agree to these policies.

_____ (If applicable) I give consent for my child to receive treatment from Kimberly Knowlton-Young, LICSW and am doing so of free will.

_____After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize **Kimberly Knowlton-Young, LICSW** to communicate electronically with me, which will include the transmission of my protected health information electronically.

____ I grant Ms. Knowlton-Young permission to carry my telephone number in her private and confidential cell phone for purposes of scheduling and emergencies only.

Client Signature_____Date_____

Please Print full name_____

Therapist Signature_____Date_____

If minor: signature of all legal guardians:

Responsible Party_____Date_____

Please Print full name_____

Responsible Party_____Date_____

Please Print full name_____

Therapist Signature_____Date_____