Kendra McCallie LIMHP, LCSW
PSYCHOTHERAPY AND THERAPEUTIC YOGA

CONSENT FOR MENTAL HEALTH TREATMENT

Kendra McCallie, LIMHP, LCSW
6107 Maple Street, Suite B, Omaha NE 68104

I authorize the provision of outpatient mental health treatment for myself,_____ or for_____. This treatment may include such services as a pre-treatment assessment, the use of specific instruments, treatment planning, and individual, couple, and/or family therapy. I understand that my active participation and compliance with therapeutic treatment and recommendations are an important component of a successful outcome of the treatment, and that treatment does not necessarily guarantee successful outcome.

I understand that it is reasonable and customary to arrive to appointments on time, to end appointments at the scheduled finish time, and to provide 24 hour notice if I need to cancel a scheduled appointment. I understand that should a pattern of canceling appointments or not showing for appointments develop, that Kendra McCallie reserves the right to refer me (or my child) to another practitioner.

I understand that all information and records generated and obtained in the course of treatment will remain confidential within Ms. McCallie's practice and will not be released to other parties without my written consent. This confidentiality will be followed according to the Health Information Portability ad Accountability Act (HIPPA) and a separate HIPPA Notice will be reviewed and signed by me and placed in the file. I understand that the confidential information may be released under the following specific circumstances:

1. If a client states intention to harm him or herself, or others, it is the Practitioner's legal duty to warn authorities and the person or persons at risk of harm or who have been threatened harm.

2. If a client reveals intent to harm him or herself, it is the Practitioner's duty to take whatever action is necessary and possible to protect that individual. Such action may include notifying the spouse, parent, family or appropriate authorities.

3. If a client becomes involved in certain legal processes, medical and behavioral health records may be subpoenaed. The Practitioner's ability to protect a client's confidentiality will be dependent on the legal situation. Records are usually subject to release in these circumstances.

4. If a client, during the course of treatment, informs the Practitioner that a child, elderly person or disabled individual is either currently being abused or neglected, or has been abused or neglected in the past, it is the Practitioner's legal and ethical responsibility to advise the authorities.

I understand that if my primary care physician or psychiatrist has referred me to Ms. McCallie, they may be routinely informed of my diagnosis, treatment protocol, and treatment progress. I understand that billing personnel will have access to my record for dates of service, demographic data and diagnosis but only for insurance billing purposes. They will not have access to any therapeutic content.

I agree to pay for Kendra McCallie's services in the form of co-payments, deductibles or co-insurance as determined by the benefits of my insurance carrier or as an agreed upon fee for service.

I have read and understand the contents of this consent form and accept the conditions of this agreement.

Signature of Client(s) (or Legal Guardian):_____Date:_____