# Confidentiality Agreement

**Please fill in this form and email it to kaahoots@outlook.com**

I do hereby seek and consent to take part in psychological intervention offered by KaaHoots Therapeutic Services (KTS). I understand that developing a treatment plan with my Mental Health Clinician and regularly reviewing my progress toward meeting my treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises can be made to me regarding the results of treatment provided. I am aware that I may stop my treatment at any time, and I agree to notify my Mental Health Clinician if I decide to stop treatment. I agree to accept my Mental Health Clinician's treatment recommendations and advice if stopping treatment.

I agree to pay a Service Fee of $200.00 for each 50-minute consultation session, and I agree to pay this fee prior and/or on the day of service. I understand and accept that I am fully responsible for service fees, even if an insurer or third-party payer does not pay. I understand that if payment for the services is not made within an agreed time, then the Mental Health Clinician may stop my treatment until payment is made. I also agree to pay for any future psychological services relating to my treatment, including psychological report writing fees, subpoena fees, and court attendance fees plus any travel fees.

I understand that there are limits to the confidentiality of information that I disclose in treatment, particularly if this information relates to harming myself or others, or if it is required by law (e.g. subpoena or mandatory reporting).

I understand that my Mental Health Clinician has a duty of care to contact and inform my next of kin, treatment providers, or emergency services if there is any concern in relation to my own or others' wellbeing or safety. I also understand that if referred by a Medical Practitioner for opinion and management through a referral and/or treatment plan, then disclosure to my Medical Practitioner about my diagnosis, treatment plan, and progress in treatment is required for any insurance and Medicare claiming purposes. I am also aware that if an agent of my insurance company or another third-party payer is providing payment of my fees, then they may be given information about the type, cost, date, and provider of services I receive along with progress reports and treatment recommendations. I hereby consent to this limited exchange of information with my referring Medical Practitioner, Insurer, and/or Third-party Payer.

**CANCELLATION POLICY**

I know that I must call ahead to cancel an appointment at least 48 hours before the time of an appointment, otherwise a Cancellation Fee of $110.00 (incl. GST) will be charged. I agree to be responsible for making and cancelling all appointments and agree to pay for all cancellation fees that I may incur. I understand that if I provide no cancellation notice and my Mental Health Clinician is not able to contact me within a reasonable timeframe, then my Mental Health Clinician has a duty of care to contact my next of kin to ensure my safety and wellbeing, and if they cannot ascertain this from my next of kin then they will inform emergency services and request a welfare check.

I understand that any other disclosures about my treatment will require my verbal and/or written consent. I understand that this agreement will become part of my record of treatment and that it may also be used for financial accounting and/or business administration purposes.

My signature below indicates that I fully understand and agree to all these terms and conditions and have discussed any of my concerns about these with my treating Mental Health Clinician.

Signature of Client:

Name:

Date:

Signature of Parent Carer:

Name:

Date: