KPCS
Kansas Professional Counseling Services

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Client Informed Consent, Rights and Responsibilities

Kansas Professional Counseling Services

Welcome to Kansas Professional Counseling Services (KPCS). This document contains important information about our mental health counseling services and polices. It also contains information about the Heath Insurance Portability and Accountability Act (HIPPA)- a federal law providing privacy protection and patient rights about the use and disclosure of your Protected Health Information. Your signature will represent your understanding of the services and policies of KPCS.

Please initial that you have read, agree to, and understand the following:

_____I understand my rights as a client to be treated with dignity, respect, and to actively participate in my treatment planning.

_____I understand my KPCS provider is a professional in the mental health field, licensed by the State of Kansas to provide such services. My provider has met specific clinical and professional standards and follows a code of ethics pertaining to the mental health field.

_____I understand there may be both risks and benefits associated with mental health services. Risks may include experiencing emotions such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness as a part of the therapeutic process. I have discussed any specific concerns regarding the counseling process with my provider.

_____I understand the counseling process requires an active effort on my part. Counseling requires a collaborative effort between the provider and client, and I will work to follow through with my treatment recommendations.

_____I understand I have a choice to actively participate in mental health counseling services with KPCS. If I have questions or concerns about KPCS procedures, they may be discussed openly as they arise. If I continue to have concerns with the services I am receiving I may decide to discontinue services. KPCS will assist me in locating a new provider if I would like them to do so.

_____If my counseling services are court ordered, and I decide not to actively participate with KPCS, I understand there may be consequences for this decision.

_____I understand KPCS will utilize the "minimum necessary" rule, meaning, my provider will make reasonable efforts to use, request, or disclose to others only the minimum amount of Protected Health Information which is needed to accomplish the intended purpose of the use, request, or disclosure.

_____I understand KPCS is mandated to report child abuse and neglect, or any suspected child abuse or neglect, to the appropriate authorities.

_____I understand KPCS has a duty to warn others as necessary to prevent or lessen a serious and imminent physical threat to a person, self, or the public.

_____I understand I have a right to revoke, in writing/by signature, any authorization to release confidential information to which I previously consented. This does not apply to information that has already been submitted or shared; information cannot be retracted. I understand if my services and authorizations to release confidential information are court ordered, there may be consequences for my decision to revoke the specific releases pertaining to the court's order.

_____I understand there is a cost associated with the counseling services provided by KPCS; I am responsible for payment. I have been informed there is a cost of $130.00 per therapy hour, $150.00 per intake/initial assessment, $100.00 per drug and alcohol evaluation, and $500.00 per mental health evaluation. I understand my KPCS provider charges $130.00 per hour for court testimony, and $60.00 per hour for preparation of court reports associated with the services received from KPCS. I understand my insurance provider will not reimburse the costs associated with court testimony and court preparation. It is my responsibility to cover all costs that not covered by my insurance provider. *This statement does not apply in full to those insured by Medicaid/KanCare; KPCS has informed me of additional information if I am covered by Medicaid/KanCare.*

_____I understand if an emergency arises I can call 316.573.2744 for assistance. I can also email KPCS at info@kpcs.com, or email my provider at the direct email. KPCS requests I leave a voicemail describing the extent of the emergency/crisis with a call back number. A return call will not be made unless a voicemail is left.

Rights of Insurance Provider Members:

Right to Receive Information: Each member has the right to receive information about Kansas Medicaid/Medicare/Private Insurance and their policies, procedures, services, providers, and the member's rights and responsibilities.

Right to Dignity and Privacy: Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

Right to Receive Information on Available Treatment Options: Each member is guaranteed the right to receive information on medically necessary available treatment options and alternatives, prescribed in a manner appropriate to the member's condition and ability to understand.

Right to Participate in Decisions: Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

Right to be Free from Restraint or Seclusion: Each member is guaranteed the right to be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Right to a Copy of Medical Records: Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected.

Free Exercise of Rights: Each member is free to exercise his or her rights, and exercising those rights does not adversely affect the way the member is treated by Kansas Medicaid/Medicare/Private Insurance or the provider.

Freedom to Change Providers: Kansas Medicaid shall not impose a limitation of the member's freedom to change mental health provider.

Kansas Medicaid members also have addition rights and responsibilities:

- To choose his/her provider
- To request a therapist who understands his/her language and culture
- To receive needed services at convenient times and places
- To obtain access to services within the specified access and standards
- To treat others with consideration and respect
- To be at appointments on time
- To call if he/she must cancel an appointment
- To be part of the treatment team by informing your doctor or therapist about symptoms and to ask questions
- To tell the doctor or therapist if you do not agree with the recommendations
- To tell the doctor or therapist when/if you want to end treatment
- To take medication as prescribed and to tell the doctor if there is a problem
- To carry his/her insurance cards
- To tell the provider if they have other insurance
- To follow plans and instructions for care that they have agreed on with providers

Right to Second Opinions: A final important Right Kansas Medicaid Members need to know about is the right to request a second opinion. Members can request a second opinion from a licensed mental health professional within the Kansas Medicaid Network.

CONSENT TO TREATMENT:
Your signature indicates that you have read this Informed Consent and agree to all terms and conditions. Your signature also indicates you have been informed of the costs associated with the services provided by KPCS as well as your Rights and Responsibilities as a client.

_____ _____

Signature of Client (age 14 and older) Date Printed Name of Client

_____ _____

Signature of Parent/Legal Guardian Date Printed Name of Parent/Legal Guardian