

Kathy Doyle MSW LCSW

10207 Woodknoll Rd.
Louisville KY 40223
859-806-2029

www.kathydoylelcsw.com
kathydoylelcsw@aol.com

STATEMENT OF AGREEMENT

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is *required by law*. Exceptions to confidentiality include, but are not limited to:

- If you are an immediate danger to yourself.
- If you threaten to harm someone physically or destroy property.
- If you disclose information about child abuse or neglect.
- If you disclose information about the abuse or neglect of a dependent adult.
- If a court subpoenas me to testify or subpoenas my records.
- If an insurance company is helping to pay the fee and requires information about your diagnosis and/or reports about your treatment.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or their representative in order to process the claims. If you instruct me to do so, only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information.

Telephone and Emergency Procedures: At the beginning of therapy we will work to establish a list of self-care strategies for you to use. Practicing these will often times prevent the need for urgent calls between sessions. If you need to contact me between sessions, please leave a message on my voicemail and your call will be returned as soon as possible. If an emergency situation arises and you need immediate assistance or you are an immediate danger to yourself, please call 911 or go to the University of Louisville Emergency Room where a psychiatrist is always on call.

The Process of Therapy: Participation in therapy can result in a number of benefits to you, including improving relationships and resolution of the specific concerns that led you to seek therapy.

Psychotherapy requires your active involvement, honesty, and openness in order to make the changes you desire. In the first few sessions I will gather information from you and we will work together to develop a treatment plan to help you achieve your goals.

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I am likely to draw on various psychological approaches based on the problem that is being treated and the assessment of what will best benefit you. Together we will also develop a self care plan with various strategies that will also assist your progress between sessions.

No Shows: In the event that you do not cancel and do not attend a scheduled appointment, I will make a call to facilitate rescheduling or provide any necessary assistance. If you have not responded within 15 days, services will be terminated.

Termination: If at any point during the psychotherapy, it is determined that you have reached your therapeutic goals, treatment will be deemed complete. You have the right to terminate therapy at any time.

Grievances: Any written grievances will be addressed within two weeks after I have received it. An appointment will be set to discuss your complaint at no cost to you. If a grievance is not resolved it may be forwarded to the State Board of Examiners of Social Work

Please note that I am under no obligation to accept clients and will not accept or continue with clients who, in my opinion, I cannot help. Upon request, referrals may be made to other qualified professionals.

My signature signifies that I have read and understand this agreement and that I have received a copy of this document.

Client Signature _____ Date: _____