

Kelley Armbruster, LISW, DAPA, LLC
7577 Central Parke Boulevard
Suite 313
Mason, OH 45040
513-770-0800
Fax# 513-770-0888

Welcome to my office! I am a Licensed Independent Social Worker and Diplomate of the American Psychotherapy Association. I provide counseling to individuals, families, couples, children and adolescents. My areas of expertise include marital counseling, relationship counseling, trauma work, depression, grief and loss, blended family issues, adolescents, children and infertility counseling. I have experience in both inpatient and outpatient settings and have been practicing for over 16 years.

The purpose of this information packet is to inform you of the policies of my practice. To ensure that you have read, understood and agree to these policies, your signature is required on the opposite side of this sheet. I have provided a second copy of these policies for you to keep for yourself.

THERAPY SESSIONS

Psychotherapy sessions are at least 45 minutes in duration. Every effort will be made to begin and end sessions on time. I do not like to keep my other clients waiting for long periods of time. Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor's visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. You are free to leave therapy at any time and I will provide you with referral providers at your request.

FEES

The fee for the initial evaluation is \$120.00. Sessions after that are at least 45 minutes in length and do not exceed one hour are billed at \$95.00. **Any phone calls that require my attention are billed at the rate of \$25.00 per quarter hour, with a minimum charge of \$25.00 regardless of the length of time involved.** Please note that payment for phone time rests with

the client, as INSURANCE COMPANIES DO NOT REIMBURSE FOR PHONE TIME. All payments for phone call time must be made before the next session. **By signing this form, you agree that you will pay the above rates.**

COURT/ATTORNEY FEES

In the event that I am subpoenaed or otherwise involved in any type of court proceeding related to my treatment of you, or your child, if your child is my patient, regardless of who involves me in the proceedings, you agree to pay for my time at a rate of \$200.00 per hour, in addition to other costs and expenses that are associated with the subpoena or proceedings, including but not necessarily limited to, travel time, associated attorney fees, time spent on the preparation of reports for the proceedings, as well as for any other expenses related to your, or your child's, case. These charges, whether for my time or the related expenses, shall be due and payable by you, as I determine they are necessary to participate in the proceedings. I require a \$1500.00 retainer before I am able to testify or attend any court proceeding and I need to receive the retainer at least 3 weeks prior to the court proceedings. If the entire retainer fee is not used, it will be refunded to you within a reasonable amount of time after the proceedings end. By signing this form you agree to pay the fees associated with legal proceedings.

PAYMENT OF FEES

Please make checks payable to Kelley Armbruster, LISW, DAPA, LLC. There is a \$30.00 charge for all returned checks. I do accept MasterCard and Visa for payments.

If you are using insurance, your co-payment is due at each office visit. It is your responsibility to obtain all referrals for services and pay any unpaid bills if your insurance denies the claims. If I am **not** on your provider panel for your insurance company, you must prepay all charges. You agree that any unpaid bills may be sent to collections. You will be notified in writing before any such action is taken. By signing this form you are stating that you understand that you are responsible for payment of all no-show fees, late cancellation fees, telephone counseling fees, psychotherapy fees, and co-payments. You understand that if you do not pay your bill within a period of 60 days that I have the right to send your balance due to a collection agency.

APPOINTMENTS/CANCELLATIONS

Your appointment is reserved exclusively for you. If you cannot keep your appointment, please give me as much advance notice as possible. For your convenience, my voice mail is available to you 24-hours a day. Please call and leave a message any time day or night. **IF YOU CANCEL AN APPOINTMENT WITHOUT GIVING A 24-HOUR NOTICE, YOU WILL BE BILLED FOR THE SESSION.** Late cancellation and no-show charges are not reimbursed by insurance companies and will be your responsibility to pay in full prior to the next scheduled session. **The charge for a 1st time NO SHOW or late-cancellation is \$40.00. For the 2nd NO SHOW or late cancellation the charge increases to \$50.00.**

EMERGENCIES

In case of a psychiatric or other type of emergency, please go to the nearest emergency room. If it is a child involved, go to Children's Hospital Emergency room at 333 Burnet Avenue (#513-636-4293). If talking to a trained professional would be helpful, call #513-281-CARE. These resources are available 24-hours a day, seven days a week, including holidays.

CONFIDENTIALITY

You should understand that all information you disclose to me is held in the strictest of confidentiality and may not be released without your written consent EXCEPT AS REQUIRED OR ALLOWED BY LAW. Some exceptions to confidentiality include, but are not necessarily limited to, situations where there is:

- A danger to you or another person, which requires me to provide protection to you and/or the other person(s).

- o Actual or suspected abuse or neglect of children/minors, developmentally disabled/mentally retarded individuals, and/or the elderly (Kelley Armbruster, LISW, DAPA is mandated or allowed by law to disclose this information to the proper authorities).
- o Presentation of a valid court order

In addition, you agree that at times I may need to discuss clinical situations/issues with your primary care or other health care provider as well as my practice attorney. I may also submit information to the Ohio Department of Insurance on prompt payment issues, I may be required to send information on unclaimed funds to the appropriate state agency, and I may need to reveal information about you if I file a collection action for non-payment of fees due to me. In all of these cases, I will reveal only the minimum amount of information necessary to accomplish each task.

PLEASE NOTE THAT IF THE CHILD IS THE PATIENT THAT UNLESS BLOCKED BY COURT ORDER, BOTH PARENTS HAVE EQUAL RIGHTS TO THE CHILD'S RECORDS.

INSURANCE AND BILLING INFORMATION

All clients must complete and sign a client registration form. For clients using insurance, we must have a copy of the front and back of your insurance card.

All billing questions must be submitted in writing to: Kelley Armbruster, LISW, Billing Dept. 7577 Central Park Boulevard Suite 313, Mason, OH 45040.

If health insurance reimbursement is sent directly to you instead of to my office, payment must immediately be made to this office. Although I may have entered into special payment arrangement contracts with certain insurance companies, please understand that your insurance contract is between the insurance company and you, the insurance cardholder and payer of the insurance premium, not with me, the provider of the service.

By signing below, you agree that you have read the information provided above, have been allowed to ask any questions that you may have, and you agree to abide by these policies and procedures, to pay all fees due as set forth in this agreement, as well as consent to the release of your information as provided above. This agreement will be effective for as long as necessary for billing and/or clinical purposes.

Client's name (printed)

Client's/Parent's/Guardian's Signature

Date

Second Parent's Signature

Date