KYLE WILLIAMS LMSW ACSW

Solution Focused Individual and Family Therapy

TREATMENT AGREEMENT and CLIENT PROFILE

Welcome to Coaching Partnerships, LLC (d.b.a. Kyle Williams, LMSW ACSW), a professional psychotherapy practice. **The Treatment Agreement** constitutes a formal agreement between us. You should read it carefully and raise any concerns that you have before you sign it.

The Client Profile follows this agreement. The Client Profile includes a signature line affirming that you understand the Therapy Agreement. Please complete and sign the Profile and return it to me prior to our first session.

Definitions:
I am certified to practice psychotherapy by the National Association of Social Workers (ACSW – Academy of Certified Social Workers) and by the State of Michigan (LMSW – Licensed Master Social Worker #6801084481.) My National Provider Identification Number is 1972752889.

Services:
The purpose of therapy is to understand present and historical events in your life and develop and implement strategies to help you reach personally identified goals of personal satisfaction. Therapy may address a wide variety of goals including your personal history, personal relationships both past and present, specific personal projects, life balance, job performance and satisfaction, or general conditions in your life, business, or profession. The services provided by Kyle Williams LMSW, ACSW are on topics decided jointly with you the client and me, the therapist.

Payment Procedure:
Therapy fees are at $120 per 50-minute session. Payment is due at the time of service in the form of cash, check, or credit card. Services left unpaid following treatment may be subject to additional fees. Additional services requested, reports, extended consultations related to your treatment or that of your family will be billed at the established hourly rate. Fees for returned checks, declined credit card payments, and all costs of collection are the full responsibility of the client.

Insurance:
I do accept some insurance. Be aware that doing so requires that I assign a psychiatric diagnosis to you – otherwise our work is not a covered medical expense. If we agree to

pursue insurance reimbursement, you are responsible for verifying your coverage for my services. I will provide you with a form for collecting this information from your carrier. You are ultimately responsible for services rendered if your insurance fails to pay. I do not have a billing or collection staff. I agree to submit your insurance with the understanding that you will follow up with your carrier to assure prompt payment of submitted billing.

Therapy and Psychotherapy:
I am trained and licensed to help people comprehend complex present and historical situations, learn new skills, and make significant behavior changes. I offer my skills in the areas of human behavior, interactive counseling techniques, communication, problem solving, motivation, and behavior change. I do this through a service called "therapy," in which you come to me for help in processing events, and making decisions and implementing them in order to achieve goals that you decide for yourself and/or your family.

As your therapist, my job is to help you understand the present and historical contexts of your life. With understanding we can take information and skills that you already have and (1) make decisions about which changes you would like to make, (2) develop a personalized plan in order to make those changes, (3) to implement your plan and make the behavioral changes, and (4) to develop strategies to maintain the changes you have made. I will support, encourage, teach, and help you stay on track toward your goals.

Though I am here to help you do so, you as the client set the agenda for your therapy. Your success will depend on your willingness to define and take risks and try new approaches. You can expect me to be honest and direct, asking straightforward questions, and using challenging techniques to help you move forward. In collaboration with me, you are expected to evaluate your own progress, and if the therapy is not working as you wish, you should immediately inform me so we can both take steps to correct the problem. As much as any human endeavor, therapy can involve feelings of distress and frustration that accompany the process of change. Though therapy can be quite successful in most instances, it does not offer any guarantee of success.

Confidentiality:
Confidentiality of the communications within therapy is a requirement of the Michigan Department of Community Health Licensing Board of Social Work as well as the National Association of Social Worker's and Association of Marriage and Family Therapist's Codes of Ethics. I will not discuss our work together with anyone outside of those specifically involved in your treatment with me. Likewise, I will not discuss the work of others participating in therapy in my practice with you. For your protection, information about your therapy will only be released with your written permission, or as required by a court order.

There are some situations in which I am legally obligated to breach your confidentiality in order to protect others from harm, including (1) if I have information that indicates that a

child, elderly, or disabled person is being abused, I must report that to the appropriate state agency and (2) if a client is an imminent risk to him/herself or makes threats of imminent violence against another person, I am required to take protective actions. I will make every effort to discuss it with you before taking any such action.

In smaller communities, seeing your therapist around town is a distinct possibility. I will not under any circumstances approach you or acknowledge a prior or existing relationship with you. This is not meant as an unfriendly gesture, but one that protects your rights of privacy. You however may greet me or choose not to greet me as you wish. Likewise, I do not see the choice not to greet me as an unfriendly gesture – I respect your privacy! If you do choose to initiate communication, topics from therapy are never to be discussed outside of the therapy environment.

It is also possible that you might see an acquaintance entering or leaving the office. You are expected to treat such contact with the utmost discretion and confidentiality both in the office and away from it. Your peer has agreed to do the same.

It is also important to understand that therapy is a professional relationship. While it may feel at times like a close personal relationship, it is not one that can extend beyond the professional boundaries of my office, either during or after our work together. Considerable research shows that when professional and personal boundaries in therapy blur, the hard-won benefits gained from the therapy relationship are endangered.

As you are probably aware, it is impossible to protect the confidentiality of information that is transmitted electronically. This is particularly true of E-mail and information stored on computers connected to the Internet and if you use a cordless or cell phone, someone with a scanner could hear you talk. I make contact through the Internet available to clients, but suggest that it be used for issues of purely logistic concerns (appointment scheduling, etc) rather than discussions of therapy issues.

For a full description of specific health information privacy policies required by HIPAA, see Notice of Privacy Practices posted on my website under the forms section at www.kylewilliams.net.

Feedback:
Therapy is a relationship between the two of us. As with any relationship, there is the possibility of ups and downs, communication concerns, misunderstandings, etc. If, at any time, you feel that your needs are not being met or you are not getting what you want out of the therapy, please tell me so we can discuss your needs and adjust your treatment as needed. Your needs are important to me and there is considerable research that says that open communication between client and therapist regarding adjustments in approach, style, content, and communication improve your outcomes in the therapy process.

(Continued)

Session Time and Attendance:
Therapy is scheduled at a time of our mutual convenience. The day and time for your next session will be scheduled at the close of each therapy session or may be scheduled by telephone or email. Please understand that the time scheduled for your therapy is held specifically for you. Any requests by other clients for the same hour are declined. You are responsible for keeping this appointment and **you are financially responsible for the session regardless of your attendance.** I will make reasonable efforts to reschedule sessions when notified in a timely manner.

I (client) understand the Session Time and Attendance sub-section of the Therapy Agreement:

Client (or Guardian) _____ Date: _____

Conclusion of Treatment:
I fully support the termination of treatment when you have come to a place that feels right to do so. You may end your treatment at any time by providing me with one week's notice. Deciding to end treatment is your decision, however as anticipating terminating treatment and actually terminating are generally relevant therapy issues, you understand that you are encouraged to make every effort to discuss this decision with me. Again, I support the termination of treatment at the time of your choosing – I am committed however to doing so in the most healthful fashion and that requires that we talk openly about ending our work together when that time comes.

Acceptance of this Agreement:
Your signature on the attached Client Profile indicates that you have read the **Therapy Agreement** and agree to abide by its terms during our therapy relationship

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CLIENT PROFILE

* Please skip information below that is irrelevant – alternate addresses, phones, etc

Date Prepared _____

Name: _____

Mailing Address: _____

City/State: _____Zip: _____

Telephone: _____ Messages OK? Y / N

Text: _____ Messages OK? Y / N

E-mail Address _____

(For your privacy, telephone, text and email messaging is for appointment purposes only – not for discussion of therapy related issues)

Date of Birth: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Your signature below indicates that you have read the information in the **Therapy Agreement** and agree to abide by its terms during our therapy relationship.

Client_____ Date _____

Therapist_____ Date _____

KYLE WILLIAMS LMSW ACSW

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Credit Card Processing Agreement

I, _____ hereby authorize Kyle Williams LMSW, ACSW to keep my signature on file and charge my credit card for therapy services. The charge will appear as "KyleWilliams.net."

I understand that I will be billed the business day upon which my therapy session occurs.

I authorize Kyle Williams LMSW, ACW to bill my credit card for additional therapy services as specifically agreed upon in advance by both parties.

I understand that I am responsible for fees incurred in the unlikely event of declined credit card charges.

This agreement will be in effect until services have been completed or until Kyle Williams has received written notification of termination in writing.

My credit card information:

[ ] Visa **[ ] Mastercard** **[ ] American Express**

Credit Card Number: _____

Expiration Date: _____

Card holder's Signature: _____

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Directions to 17 N. 4th Street, Grand Haven:

M-31 North or South, turn on Jackson street towards Downtown Grand Haven. Go 3 blocks and immediately after crossing the railroad tracks, turn left on 4th Street. Follow 4th Street for 3 blocks and my office is on your right, at the corner of 4th and Columbus Streets. It is a one story brick building that says **Central Park Building** on the side.

Parking: There is usually on-street parking available right in front of my office on 4th Street, on the North side of the street. If not, just past the building is a driveway on your right. You can park behind the building in the parking lot in the spaces marked for visitors.

My office is on the main floor - Suite 211

If you get turned around, my direct line is 616.402.1389

MentorCoach™ • Licensed Master Social Worker • Academy of Certified Social Workers
17 N. 4th Street / Grand Haven, MI 49417 / Phone: 616.402.1389 / Fax 650.412.1389
Web: coach@kylewilliams.net • www.KyleWilliams.net