

Counseling Office Policies

Kim Smith Iverson Counseling, LLC-LCSW, CSAT

Licensed Clinical Social Worker—Certified Sex Addiction Therapist
270-392-4656

Kim Smith Iverson, LCSW, CSAT received her BS in Social Work from Western Kentucky University in 1984 and her Masters Degree of Science Degree in Social work from the University of Louisville Kent's School of Social Worker in 1985. She has over 30 years of training and experience as a psychotherapist in treating people with issues related to mental health, addictions, domestic violence, trauma and codependency, in the private practice arena, residential addiction industry and community mental health. She received her License as a Clinical Social Worker (KY-1257) in 1998. Kim specializes in the area of intimacy disorders, relational betrayal, love, relationship and sex addiction. Kim has been intensively trained as a Certified Sex Addiction Therapist (CSAT 2014C-1877) through the International Institute for Trauma and Addiction Professionals (IITAP). This CSAT certification and training was developed by the world renowned therapist and researcher, Dr. Patrick Carnes and requires attendance at multiple training modules and supervision with a CSAT® supervisor. Kim is also Level One Certified in the Marilyn Murray, "Murray Method" which is used to treat individuals with unresolved trauma, addictions and abuse.

In addition to Kim's work in the private practice arena, she also serves on the clinical staff at The Bridge to Recovery--a residential program for those struggling with addictions, trauma, and codependency, where she facilitates intensive inpatient clinical services for sex addicts and their partners. Prior to Kim's work as a clinician at The Bridge to Recovery, she was the Clinical Director there for almost 5 years.

Confidentiality: Client confidentiality is respected at all levels of communication and is protected by Federal Law. I understand that all communication between my therapist and myself are confidential and will not be shared with anyone unless I have signed a release of information. **However**, there are indicators in which my professional and legal duty overrides the dictates of confidentiality. Briefly, these indicators are imminent danger to self or others and abuse of a child, an elder or a dependent adult or if ordered to do so by a judge in a court of law. I am required by law to break confidentiality and notify the appropriate people of imminent harm in order to safeguard life. Please discuss the limits of confidentiality with me.

Client's Initials _____

Release of Information/Client Records: I keep records of our sessions on a secure HIPPA compliant practice management software program called therapynotes.com. Under KRS 422.317 I am required to provide you with ONE free copy of your records for services rendered at my practice upon written request. If you request that your records be forwarded to another designee, following the execution of a valid Release of Information, there will be a fee of \$5.00 a page, payable by the client/client representative before records are released.

Client's Initials _____

My strong preference is that I do not either discuss cases with or release records to attorneys. I also prefer not to testify in legal proceedings. If, as a result of the client or client representative signing a Release of Information, I am required to discuss the case with an attorney, court officers (such as probation, parole, guardian ad litem) or give legal testimony in any type of legal proceedings such as (but not limited to) disability determinations, civil or criminal depositions or court testimony, or I am

required to write letters, make telephone calls, or electronic correspondence to attorneys or legal representatives, you agree to the following:

- A deposit of \$800.00 will be made by client before any correspondence or discussion takes place. My professional fee of \$200.00 per hour (pro-rated every thirty minutes) for legal testimony will be subtracted from this retainer. Travel time to and from legal testimony as well as time spent waiting for legal testimony is included in this fee. If there is a balance, one-half of it will be refunded. Time above 4 hours will require an additional deposit of \$800.00 and will be handled as above.

Client's Initials ____ ____

- If at any time, because of being involved in client legal proceedings, I feel that I need my own legal representation for any reason, the client/client representative will be responsible for paying my full legal fees in the manner prescribed by my attorney.

Client's Initials ____ ____

- Involving me in legal cases will probably result in the client being discharged from care.

Client's Initials ____ ____

Fees and Payments: Length of sessions can vary to meet your scheduling needs and financial needs. Fees are as follows: (additional 3% charge for debit/credit card)

\$120.00 per 50 minute session

*In extreme cases of financial hardship, a discounted session rate can be discussed but are available on a limited basis.

Payment is expected at the time of the session. Returned checks or declined credit card/debit card/HSA charges for any reason will incur a \$50.00 charge. If the returned/declined item is the fault of your crediting agency, you must be reimbursed for this charge by them and not by my office. In the event that your account becomes 45 days past due, I reserve the right to terminate the professional relationship and place the account with a collection service. All costs, fees and related expenses of the collection effort will be borne by the client/guarantor.

Client's Initials ____ ____

Insurance: Insurance is not accepted; however, some insurance companies may reimburse an "out of network" Licensed Clinical Social Worker/Mental Health Service Provider. If filing, I will provide you with a comprehensive billing statement, upon request, that you can submit to your insurance provider for potential reimbursement. Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by asking the following questions:

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- How many sessions per year does my health insurance cover?
- What is the coverage amount per therapy session?
- Is approval required from my primary care physician?

Client's Initials ____ ____

You are responsible for coming to appointments on time and at the time we have scheduled. **Sessions last 50 minutes without exceptions.** If we decide to meet for a longer session, I will bill you prorated on

the regular fee in 30 minute increments. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel less than 24 hours notice, you must pay the entire fee that I would have received for that session. My voicemail has a time and date stamp which will keep track of the time that you called to cancel. As a courtesy to you, I will send an appointment reminder to your cell phone (text) or your home phone unless you specifically ask me not to. By signing this form, you give me permission to send such a reminder. Please note that if for some reason there is a failure to remind you of your appointment, you are still ultimately responsible for attending your appointment.

You are normally the one who decides when therapy will end, with three exceptions: if we have contracted for a specific number of sessions. If I am not, in my judgment, able to help you, because of the kind of problem you are having or because my training and skills are not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you are violent, threaten (verbally or physically) or harass me, my office, or my family, I reserve the right to terminate services immediately. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

Client's Initials _____

Phone Calls/Written Correspondence: Phone calls to/from clients or on behalf of clients over 5 minutes (excluding calls to/from legal representatives) are billed at \$100.00 per hour, pro-rated every 15 minutes. Written correspondence, including emails to/from clients or on behalf of clients (excluding that to/from legal representatives) is also billed at \$100.00, prorated every 15 minutes. Please note, I will not answer client phone calls past 5:00pm or on Saturday or Sunday as this is my time with my family.

Client's Initials _____

I understand and agree that I am responsible for payment of any and all services provided to me and/or my dependents and/or my spouse by Kim Smith Iverson, LCSW, CSAT at the time of the service is rendered or in advance. No temporary or convenience checks accepted.

I understand that Kim Smith Iverson, LCSW, CSAT is in private practice and is not available on a 24-hour basis, seven days a week. Consequently, if I am unable to reach her, I will contact the HELP LINE (270)-843-HELP, dial 911 or proceed to the nearest local emergency room.

I HAVE READ THE ABOVE AND AGREE TO ABIDE BY AND BE BOUND BY THESE POLICIES. A copy of this signed statement is as valid as the original.

Client Signature Date

Parent/Guardian Signature Date

____ YES ____ NO I give permission for Kim Smith Iverson, LCSW, CSAT to call me to confirm appointments at my home or my place of employment, including leaving a message on an answering machine or voice mail or via text message.

Home Number: _____ Cell Number: _____

