Kelland Psychological Services, LLC

Limitations on Patient Confidentiality | Consent for Assessment, Evaluation, or Treatment | Acknowledgement of Notice of Privacy Practices

Welcome to Kelland Psychological Services, LLC (KPS) located at 30 Crossing Lane, Suite 201, Lexington, VA 24450. Psychological services offered by KPS are provided by Chad J. Kelland, Psy.D., Licensed Clinical Psychologist, Commonwealth of Virginia. Your signature below indicates you are aware of the following policies and procedures regarding patient confidentiality, informed consent, consent for treatment by a Licensed Clinical Psychologist, and notice of privacy practices. At your request, the KPS will provide you with a paper copy of the Notice of Privacy Practices at your request. That notice contains information about how your Protected Health Information (PHI) will be protected and your rights as a patient.

SESSION LENGTH, COSTS, & DURATION OF TREATMENT:

Individual psychotherapy sessions at KPS have session length of 45 minutes. Family or couple's sessions have a duration of 55 minutes. The amount of time required for a psychological evaluation is dependent on the purpose of the assessment. Psychological evaluation/assessment session durations and reporting requirements will be determined and discussed with the patient and his/her family (as appropriate) prior to the commencement of the assessment.

Costs for individual, family, and couple's psychotherapy sessions are determined at the start of treatment. Psychological assessment or evaluations fees are determined based on the requirements and purpose of the evaluation or assessment. The cost for sessions will be covered by (please check):

- ▫ patient at a rate of _____/session
- ▫ by patient's medical insurance
- ▫ by the organization requiring the treatment or evaluation

____/____ (Initials/Date)

CONFIDENTIALITY:

Information disclosed during services provided by KPS to Chad J. Kelland, Psy.D. is strictly confidential and will not be released to any third party without written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to:

1. Reporting suspected child abuse, elder abuse, or dependent adult abuse.
2. If the provider has knowledge or suspects that the patient may be a danger to her or himself or to another person or property.
3. If the patient is gravely disabled.
4. If disclosure is court ordered.

In the event a patient is injured, or hospitalized, this document will serve as written consent to share confidential patient information as needed with necessary healthcare personnel. _____ /_____ (Initials/Date)

INFORMED CONSENT:

You have the right to be informed about mental health treatment options and have the right to consent to or refuse any proposed treatment or test. You will be provided with a medical diagnosis or suspected diagnosis. You will be informed of the nature, purpose, potential risks, complications and/or side effects of available treatment options. You will be informed of the possible consequences if medical advice/treatment is not followed.

CANCELLATION POLICY:

It is expected that you will provide at least twenty-four-hour (24) notice of any cancelling or rescheduling of an appointment. Should you be late to your appointment by fifteen (15) minutes or more, Dr. Kelland reserves the right to cancel and reschedule the appointment. In the event that you have three or more missed appointments in a row, a portion of the next completed session will be used to explore if individual psychotherapy is a good use of your time, if there are any undiscussed relational issues between you and your clinician, or if you have met all of your treatment goals and objectives.

EMERGENCY SERVICES/CRISIS SITUATION:

KPS is not a 24-hour care facility. If a mental health emergency occurs outside of typical business hours, seek immediate medical or psychological attention at *Stonewall Jackson Hospital Emergency Room* located at 1 Health Circle, Lexington, VA 24450 or call 911.

I, the undersigned patient and/or legal guardian, authorize treatment by Chad J. Kelland, Psy.D., Licensed Clinical Psychologist. I have read, understand and agree to all of the above. Signature below indicates that you consent to the treatment discussed during your initial session with Chad J. Kelland, Psy.D., Licensed Clinical Psychologist.

_____ _____

Print Name Signature

_____ _____ _____

Legal Guardian (if patient is under 18-years-old) Legal Guardian Signature (if patient is under 18-years-old) Date

_____

Witness

Patient Id#: _____

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