

# Mary Rhea, MA, LPC

20 W. 9th Street • Kansas City, MO 64105 • (816) 287-0457 • [mtrhea@gmail.com](mailto:mtrhea@gmail.com)

**IMPORTANT INFORMATION AND CLIENT CONSENT:** Please read and sign at the end stating you have fully read and understand the information below.

**GENERAL GUIDELINES:** Counseling requires a great deal of participation and cooperation from the client. Your effort will be important in determining how much benefit you will receive. Much of what occurs during a session is dialogue. You will be expected to relate not only problems and concerns, but successes as well. At times you may be given homework assignments such as reading, keeping a journal, monitoring your own behavior, practicing new behavior, etc. You may also be asked to complete some questionnaires and/or tests. If a need for medication to relieve emotional discomfort or psychological difficulties seems indicated, a consultation with your physician or a psychiatrist will be recommended. It is important that you regularly and promptly attend scheduled sessions. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive and healing for clients; however, the level of satisfaction for any individual is not predictable or guaranteed. I am here to support you and answer any questions or concerns that may arise throughout this process.

**CONFIDENTIALITY:** With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent in the event of an emergency. I will disclose as little information as possible relevant to the circumstances of the emergency. You may direct me to share information with anyone of your choosing by signing a written release of information. You may revoke this release at any time by written request.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in logs by internet service providers and could theoretically be read by anyone with access to these logs.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect. Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of:

- Child or elderly abuse: If I have reasonable cause to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services or Adult Protective Services within 48 hours.
- Threats of physical harm to self: If I believe that you are at imminent risk of harming yourself, I may legally break confidentiality and call the police or the county crisis team. This would be a last resort if other attempts of ensuring your safety have been unsuccessful.

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- Threats of physical harm to others: If I have reasonable cause to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police to ensure safety of your intended victim.
- Subpoena of a court: If you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called “privilege” and it is your choice to prevent me from testifying or allow me to do so. However, in some situations a judge or a court may require me to testify regardless of your non-consent.

Finally, I may occasionally find it helpful to consult other professionals about your case. During a consultation, I make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. All consultations will be noted as Protected Health Information.

**PROFESSIONAL FEES:** The standard fee for an individual session is \$90.00. The standard fee for a couples or family session is \$100.00. All sessions are 50 minutes in length. Longer sessions and phone calls in excess of 15 minutes are to be prorated on the basis of the standard session fee. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check, cash, or credit/debit card. I am also able to accept HSA/FSA debit cards. Any checks returned to my office are subject to an additional fee of up to \$25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. I am currently not able to directly bill any insurance company. I can supply you with a receipt of payment for services, which you can submit to your insurance company for potential reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague. I have a limited number of slots available for clients who cannot afford the standard counseling fees due to financial strain. Please contact me directly to further discuss the details of a reduced rate.

If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, you will be expected to pay the full amount of the scheduled session, unless we both agree that you were unable to attend due to circumstances beyond your control.

**PROFESSIONAL RECORDS:** I am required to keep appropriate records of the counseling services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request.

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You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

**CONTACTING ME:** My direct contact number is 816-287-0457. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible or within 48 hours. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please contact 911 or go to your nearest emergency room for immediate assistance. If I will be unavailable for an extended time, I will inform you of my absence and provide you with the name of a colleague to contact if needed.

**REVOCATION:** Either party may revoke this contract at any time. Your revocation will be binding on your therapist unless action has been taken in reliance on it; if there are obligations imposed on your therapist by law or if you have not satisfied any financial obligation you have incurred.

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Client Name (printed)

Authorized Signature

Date

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Therapist Name(printed)

Authorized Signature

Date