

**Kristen J. Flynn, LCPC** ✂ Licensed Clinical Professional Counselor  
Kimball Health Center ✂ 333 Lincoln Street, Suite 207, Saco, ME 04072  
207.228.4596 ✂ kristenjflynn@gmail.com ✂ www.kristenjflynnlcpc.com

## **COUNSELOR - CLIENT SERVICE AGREEMENT**

### **State Licensure and Certification**

Licensed Clinical Professional Counselor  
State of Maine CC3195, Expires 12/31/2022

### **Education**

Lesley University, Cambridge, MA - Masters in Arts, Mental Health Counseling, 2004  
Tufts University, Medford, MA - Bachelors in Arts, English, 1994

### **Professional Affiliation**

Member of Maine Mental Health Counselors Association (MEMHCA)

Thank you for joining my practice. This service agreement provides you with important information about my professional counseling services and business policies. Within my practice I serve primarily adults of all ages in individual and group counseling. My areas of focus include but are not limited to depression, anxiety disorders, stress management, PTSD, co-occurring disorders, addictions, relationship issues, grief and bereavement, aging issues and adjustment struggles. From a client-centered approach, some of the methods I use in counseling clients include DBT (dialectical behavior therapy), cognitive behavioral techniques and mind-body awareness. I believe that counseling is a collaborative process in which a client has the opportunity to gain personal insight, growth and increased satisfaction and peace with one's self and life.

### **Confidentiality**

Confidentiality is an essential part of the counseling process and the client-counselor relationship. It also has its limitations. All confidentiality will be maintained in accordance with the standards, ethics and laws of the State of Maine, Federal regulations, and the American Mental Health Counselors Association. Exceptions to confidentiality include:

1. Cases involving the client's intention to do serious harm to themselves or others, and inability to contract for safety.
2. Cases in which clients request their records to be released to themselves, or a third party with a written, signed release.
3. Cases in which a court order recorder is to be made available.
4. Cases in which there is a reasonable suspicion of child abuse or neglect, or abuse or neglect of an elder or other incapacitated person.
5. Cases in defense against a legal action or formal complaint, which the client makes before a court or regulatory board.

Please know that at times, consultation with other professionals may occur in order to provide the most effective treatment possible to my clients. Consultation includes discussing a client's case, treatment modality and a client's progress in treatment. At no time will a client's identity be revealed or confidentiality broken. In the rare case that I may unexpectedly pass away, a designated clinician will have access to your information in order to close my records, and provide you with notification for next steps.

### **Group Therapy**

If attending DBT groups, group members are asked to keep information and names confidential but group therapists and individual therapists have no control over if group members will keep information confidential.

## **Communicating Through Email or Text Messaging**

If you elect to communicate with me by email or text messaging at some point in our work together, please be aware that email and texting is not completely confidential. There are risks associated with email and text messaging as outlined below:

- \*All emails and text messages are retained in the logs of the email/phone/internet service provider. While patient information is protected on GRU servers, the same may not be true for email and text message copies that are retained in the logs of your and my phone/internet service providers. Although under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers.
- \*Copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- \*Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- \*Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

Conditions for the use of email and texts:

1. I cannot guarantee but will use reasonable means to maintain the security and confidentiality of email and text information sent and received, including a passcode lock on my phone.
2. Email and texting is not appropriate for urgent or emergency situations. I cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
3. Email and texts should be concise. Unless we have agreed to a specific exception, sensitive or complex situations should be discussed in a phone call or during a scheduled appointment, not in an email or text.
4. If texts or emails contain information relevant to your treatment, they may be retained in your medical record, or a summary of the content may be included in a clinical note in your record.
5. If you choose to use email or text messaging, you agree that I may reply to your email and text messages, and that I may include any information that I deem appropriate, including information that would otherwise be considered confidential.
6. You agree that if you do not receive a timely response from an email or text message to me, that you will follow up with a phone call to one or more of the numbers provided below.
7. If you choose to use email or text messaging, you agree to not hold me liable for improper disclosure of confidential information that is caused by you or any third party.

By signing below, you agree that you have read and understand the risks associated with communication via email and text messaging, and that you consent to the conditions outlined above.

## **Fees, Appointments, Emergency Protocol Policy and Insurance**

**Fees/Appointments:** Counseling sessions are scheduled by appointment only. The fee for an initial in-take assessment appointment is \$125.00. The fee for all 60-minute sessions following the assessment is \$125.00. Your fee may differ depending upon whether or not you are using insurance coverage. If you have an insurance deductible, you will be responsible for covering it. Many insurance companies have an annual deductible, which is the responsibility of the insured. Payments, co-payments or agreed upon fees are expected at the time of the appointment via cash or check. (A \$10.00 fee, along with any subsequent bank fees, will be billed to your account for returned checks.) Please come prepared to pay any co-pay at each session. A 24-hour notice of cancellation is required, or you will be responsible for the \$70.00 no show/no cancel fee for any

missed session. Exceptions will be made for sudden illness or emergencies. Please be considerate and call ahead if you cannot make your scheduled appointment.

**Emergencies:** I can be reached at 207.228.4596. DO NOT CONTACT ME VIA EMAIL OR TEXT for emergencies. If you are having a clinical emergency and cannot reach me, the protocol of this office is for you to call 1.888.568.1112, or for you to go to your nearest emergency department.

**Risks and Benefits:** Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried to not think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide that I'm not the right therapist for you. You are free to leave therapy at any time.

**Insurance:** Some insurance companies reimburse for professional counseling. It is the client's responsibility to contact one's insurance company and inquire about the criteria for reimbursement. It is also the client's responsibility to file for reimbursement, unless I have a specific contract with your insurance company or health maintenance organization (HMO). If a client chooses to use insurance, a mental health diagnosis, supplied by the counselor, will be requested by the insurance company. This diagnosis will become a part of a client's personal medical and insurance record. HMOs will also request updated summaries on a client's progress in treatment in order to determine a continuation or denial of coverage for future treatment. In the case that a client's insurance company denies any further coverage, the client will be responsible for the full fee of the counseling session.

### **Complaints**

Please discuss all complaints or dissatisfactions with me first so we can attempt to problem solve the issue together. If unable to do so, a client always has the right to contact the State of Maine Office of Licensing and Regulation at 35 State House Station, Augusta, ME 04333-0035.

**Consent To Treat**

I (the client) am seeking evaluation and/or treatment with Kristen Flynn, LCPC. I hereby give my consent for me/him/her to receive counseling. The type and extent of services that will be provided will be determined following an initial assessment and discussion with me. The goal of the assessment process is to determine the best course of treatment for me/the client. For some treatments/services, additional consent forms may be required to explain and document your decision to receive those services.

I understand that information shared with Kristen Flynn, LCPC is confidential with some limited exceptions described more fully in the Notice of Privacy Practices. By signing below, I also acknowledge receiving a copy of the Notice of Privacy Practices.

I understand that while supportive counseling and psychotherapy, may provide significant benefits, they may also pose risks. Supportive counseling and psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Other therapies and/or services may have other risks.

In order for treatment to be effective, the active involvement of the client is required. If a client is missing a significant number of regularly scheduled appointments, we will re-evaluate whether it is possible to continue to provide clinically appropriate services. In that situation, I may advise a client that it will be necessary to discontinue services.

I understand and agree that Kristen Flynn, LCPC may release information, including the diagnosis and records of my (the client's) treatment (including mental health and substance abuse) to third party payers including MaineCare as needed, for the purpose of obtaining payment or verifying the appropriateness of reimbursement for services.

If I have any questions regarding this consent form or about the services offered, I may discuss them with Kristen Flynn, LCPC. I understand that I may stop treatment at any time and I may request a change in clinicians.

This consent will remain in effect for the duration of services unless this consent is revoked. In the event that consent for treatment is revoked, Kristen Flynn, LCPC may be unable to continue to provide services.

By signing below, I hereby acknowledge that I have read the above information, that I understand and agree to these statements, and that I have been able to ask and have answered any questions I might have.

-----  
Date            Client Signature

-----  
Date            Parent/Guardian Signature (both parents if shared parental rights)

-----  
Date            Witness Signature (sign and print name)

**Attendance Policy**

1. Any client who misses or cancels more than three (3) appointments during any six-month rolling period of time (regardless of the reason), may be discharged to make room for another client.
2. Any appointment that is missed without 24-hour advance notice will subject the client to a \$70 no-show fee. Any client who incurs no-show fees for two consecutive appointments may be administratively discharged. If a client misses more than three (3) appointments during any six-month rolling period of time, and wants to retain their standing appointment slot (described below), rather than being discharged, the client will be charged a \$70 placeholder fee for each missed appointment that exceeds the three (3) missed appointments limit.
3. No-show/placeholder fees are not covered by insurance. An overdue billing account may result in immediate discharge. Requests for additional services (such as letters of support, release of records, etc.) will not be processed while a client’s billing account is overdue.
4. All clients are admitted to treatment with a standing appointment that recurs on a mutually agreed upon regular schedule (usually weekly on the same day of the week, at the same time, or biweekly). If a client misses an appointment for any reason (including for pre-planned absences, holidays, cancelled appointment, no-shows, and inclement weather cancellations), their appointment schedule will resume with their next regularly scheduled appointment. This will continue until the client requests to be discharged, or is notified that they are being discharged.

By signing below, I hereby acknowledge that I have read the above information, that I understand and agree to these statements, and that I have been able to ask and have answered any questions I might have.

-----  
Date            Client Signature

-----  
Date            Parent/Guardian Signature (both parents if shared parental rights)

-----  
Date            Witness Signature (sign and print name)