KELLIN

☐ **Kellin, PLLC Client** ☐ **Kellin Foundation Client**

INFORMED CONSENT FOR SERVICES

Please review this agreement carefully, as it sets forth the understanding between you ("Client") and the Kellin, PLLC and/or Kellin Foundation ("Agency") regarding the services you have requested and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

THIS AGREEMENT made this _______ day of_____________________ ("Effective Date") by and between the Agency and

____

Name of Client and/ or Responsible Person

____

Street Address City State Zip Code

____

Home Phone Cell Other

Emergency Care: The Client does_____/does not____give the Agency consent to seek emergency care for them in the event that an injury or accident occurs.

____

Emergency Contact Name Relationship Phone No.

("Client") on the terms and conditions set out below:

1. **Term of Agreement**. The term of this agreement will start on the Effective Date, and will continue on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.
2. **Services Requested**. We will provide Skill Building Groups, Client Navigation, Case Management, Advocacy, Peer Support, Outpatient Assessment and Treatment and/or Psychological Services requested and agreed upon as set out in the Service Plan. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency.
3. **Termination**. Either "Client" or "Agency" may terminate this agreement at any time upon written notice to the other party. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. We will immediately refund any prepaid fees.
4. **Governing Law.** The laws of the State of North Carolina shall govern this agreement.
5. **Agency's Responsibilities**. The Agency responsibilities are outlined on the enclosed "*Rights and Responsibilities"* form
6. **Client's Responsibilities.** Your responsibilities are outlined on the enclosed *"Rights and Responsibilities"* form. You will be required to sign it.
7. **Severe/Bad Weather.** In severe weather, we may determine it is not safe for our Clinicians to travel and provide services at our office that day and may have to cancel that day's service. When this occurs we will notify you and reschedule. We follow the Guilford County Schools weather schedule and delay and close accordingly. We appreciate your understanding regarding this matter.

8. **Confidentiality.** There are some situations where disclose of information is required without either your consent or Authorization, including a court order, a government agency requesting the information for health oversight activities, if a client files a complaint or lawsuit against us for self-defense, and in some situations, worker's compensation claims. In addition, mandatory reporting laws require us to disclose information if we have cause to suspect that a child has been abused or neglected, or if we have cause to suspect that a disabled adult has had a physical injury or injuries inflicted upon such disabled adult, other than by accidental means, or has been neglected or exploited. Finally, if we determine that a client presents a serious danger to the client (yourself) or another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

9. **Teaching Facility.** I understand that this facility is also a teaching facility. I agree to allow advanced students who are training to be clinicians or allied health personnel to assist and participate in providing my care. I understand that my medical records may be used for purposes of research, education and client care. Also, I understand and agree that health care vendor representatives may be present at times during my care and treatment and may participate in my care as my health care providers deem appropriate.

10. **Billing and Payments.** You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If you have insurance, it is very important that you find out exactly what mental health services your insurance policy covers. You are responsible for your co-payment and any deductible at the time of service. By signing this Agreement, you agree that we can provide requested information to your insurance carrier or health plan.

11. **General Information.** You will be provided with a list of contact names and numbers in the event you have any questions or concerns or should an emergency arise.

Your signature and /or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of this agreement, including the following:

- You have read this agreement and agree to its terms
- You acknowledge that you have received the HIPAA Privacy Policy and Clients Rights and Responsibilities documents
- You have reviewed and agree to the Financial Agreement
- You have reviewed the Client Handbook and understand its contents
- You have had the opportunity to ask any questions that you may have related to this agreement

____
Print Name of Client

____________________________________ ______________________________
Signature of Client Date

____________________________________ ______________________________
Signature of Parent or Legal Guardian Date
(if client under 18-years-old)

____________________________________ ______________________________
Witness Date