



# Carrie Wilkerson Healing

1

Individual, Couples, and Family Therapy

(615) 205-2313 | [carrie@carriewilkersonhealing.com](mailto:carrie@carriewilkersonhealing.com) | [carriewilkersonhealing.com](http://carriewilkersonhealing.com)

## General Policies

I am glad to have the opportunity to work with you. This handout is to provide information helpful in making informed decisions concerning these services. Please ask questions at any time. I am licensed in the state of Tennessee to practice Marriage and Family Therapy under license #2160.

### Appointments

Therapy services are by appointment only. Basic sessions are 45-50 minutes, which is known as the “clinical hour.” Because the appointment is reserved for you, it is required that you communicate to me any cancellations or rescheduling needs at least 24 hours in advance of your scheduled appointment. The full rate is charged for missed appointments or cancellations within 24 hours. Scheduling and cancellations can be communicated by call, text, or e-mail.

### Charges

My standard fee for a clinical hour (45-50 min) therapy session is \$130.00 for individuals, and \$150.00 for couples and families. This fee also includes my time on your behalf outside our session, including record keeping and preparation. I accept cash, check or debit or credit cards as well. A service charge reflecting the cost of using the Square payment system will be added to the total if you choose to pay by debit or credit card. There will be a \$20 fee for any returned checks, so please be sure you have the necessary funds available when choosing your method of payment. At my option, I can require that a credit or debit card be kept in my files in order to bill for any missed appointments.

The client agrees to pay and will be billed at a rate of \$200 per hour for any and all time I spend to review, respond to, or appear for any subpoena, request for information, deposition or any legal testimony, or any court appearance related to or arising out of any therapy session attended by the client, whether such subpoena or request comes from the client’s legal counsel or any other third party. The client also agrees to pay, and will be billed for, any and all legal fees (including, but not limited to, any and all



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2

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attorneys' fees of the attorney I retain at my discretion to assist me in such matter), court costs, or any other costs I incur in the process of reviewing, responding to, or appearing for any such subpoena, request for information or documentation, deposition or any legal testimony, or any court appearance.

In addition, client agrees to pay and will be billed at rate of \$200 per hour for any and all time I spend in discussions or correspondence (whether written or verbal) with any counselor, therapist, physician or other professional treating the client at present or in the past and with whom the client consents to such discussions or correspondence.

### **Messages**

I do not accept phone calls or check email while I am with clients or outside of my regular business hours. During those times you may leave me a voicemail. It is my policy to return calls, texts or emails within 24 hours during the work week (Monday – Friday). In the case of an emergency, please call the Metro Crisis Hotline at 615-244-7444 or dial 911.

### **Use of Email, Phone and Text Messaging**

Unless a client is engaged in Telehealth Counseling as described herein, electronic communication may only be used for scheduling or questions about appointments. Tone of voice, emotions and other important communication factors are sometimes assumed or misunderstood in electronic communication so it is important to maintain the work in our scheduled session. In the case that a client feels it necessary to send an update or extra information to me in between sessions, or if I receive any such communication from client or any third-party not related to scheduling or appointments, the following shall be adhered to:

1. The client agrees to pay and will be billed at a rate of \$200/hour for any and all time I spend to review, respond to, print and file all written correspondence, text(s), or email(s), whether from the client or any third



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3

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party related to or arising out of any counseling session attended by the client.

2. If, in any such communication, it is indicated, either outright or by insinuation that the client is planning on harming themselves or someone else, the client agrees that the legal mandate of client confidentiality shall be waived.

The client agrees to pay and will be billed at a rate of \$200/hour for the time it takes to assess the situation, contact the client, develop a safety plan and contact all appropriate emergency contacts, safety and medical personnel in order to ensure the client's safety.

### **Therapy**

In-Person Therapy can be tremendously beneficial, while at the same time there are some risks. The risks may include the experience of intense and unwanted feelings such as: sadness, fear, anger, or guilt. It is important to remember that these feelings may be natural and normal and are an important part of the counseling process. Other risks of therapy may include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, alteration of an individual's thinking, and calling into question some or even many of your beliefs and values. In the process of our therapy, I will be available to discuss any of your assumptions, problems, or possible negative side effects of our working together. Periodically, we will address your progress and re-evaluate treatment as needed. However, please feel free to address these or other issues with me at any time. Infrequently, a client's distress remains or becomes so high that hospitalization or the use of medication must be considered. I am not a physician and do not prescribe medication; however, at times I may encourage you to consider seeking medical attention. In cases where hospitalization and/or medication may be required, this will be discussed in advance with you and, if necessary, with other responsible parties.

I do not perform any employment related, fitness-to-work, or employment disability or ADA evaluations and do not provide any mental health diagnoses or evaluations for the purpose of any employment related evaluations or any



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4

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disability evaluation under the ADA. I do not provide any child custody evaluations or any mental health diagnoses related to any child custody dispute, divorce, or other legal proceeding. Requests for such evaluations or services will be declined as not a part of the counseling services I provide.

### **Telehealth Therapy**

In addition to In-Person therapy, we may conduct Telehealth therapy via phone or online Internet video sessions. Such sessions shall include the same risks and benefits as set forth above for In-Person therapy. However, Telehealth therapy may involve additional risks, including my inability to gauge or determine emotions or other important communication cues or factors due to the communication medium being used. Additionally, while Telehealth therapy can be beneficial, it may not be as effective as In-Person therapy in treating your presenting problems. You are aware of these potential limitations and risks, as well as the benefits, of Telehealth therapy, and you understand that a reasonable alternative to this medium is an In-Person therapy session. If you request, I can refer you for In-Person therapy with another professional in your area. All telephone or online internet video sessions will maintain all applicable standards of confidentiality. Please consider your own safety and privacy when choosing a setting for your telehealth session.

In the event of communicable illness for me, my clients, or household members, then I reserve the right to move an In-Person session to a Telehealth session, as a one-off decision or until all parties are no longer communicable. As much notice as possible will be given to clients before such a decision is made.

### **Client Rights**

At any time you may question and/or refuse therapy or diagnostic procedures or ask questions about the process and course of the therapy. Clients are given the respect of the highest level of confidentiality. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions require:



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5

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1. That I notify relevant others if I judge that client has any intention to harm either himself/herself or another individual.
2. That I report any incident of suspected children or elder person(s) involved
3. That in legal cases, my records may be ordered by the court.

Confidentiality will be respected in all cases, except as noted above. In those additional cases where in my judgment the maintenance of confidentiality is, in fact, detrimental or destructive to you, I will inform you of my concern, and you will have the final decision as to whether or not I maintain confidentiality. When needed, you will be asked to sign a “Consent for Release of Confidential Information” form which will be to discuss your evaluation and/or treatment with others (e.g. Physicians, previous counselors, etc.). If you wish, you may also limit the time or release by an expiration date, and/or limit what I have permission to discuss by writing these instructions in the release form.

### **Working with Couples and Families: “No Secrets” Policy**

During work with couples and families, it is important that we be able to keep avenues of communication open and honest for the sake of healing and growth. If one member of the couple or family shares in confidence a secret with me that has been withheld from the rest of the unit, ultimately it will need to be shared with the rest of the unit before therapy can proceed. I will work with the secret-holder to create a plan for disclosure, including timeline and delivery. If the secret-keeper is unwilling to disclose the secret, then therapy for the unit will be terminated by me with no further explanation to the family unit.

### **Termination**

Termination of therapy may occur at any time and may be initiated by either the client or the therapist. I request that if a decision to terminate is being made that the final session may be scheduled to explore the reasons for termination. Termination itself can be a constructive and useful process. If any referral is needed or requested, it will be made at that time. If you have not contacted me or scheduled an additional session within 90 days of the last session, you agree to be considered discharged as a client.



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## **Clients Who Are Dependents**

If you are requesting services as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your dependent's therapy professional, it is important that the client is able to completely trust me. As such, I keep confidential what the dependent says in the same way I keep confidential what any client says. As the parent or guardian, you have the right and responsibility to question and understand the nature of activities and progress with the dependent, and I must use discretion as to what is an appropriate disclosure. In general, I will not release specific information that the dependent provides to me; however, I feel it is appropriate to discuss your dependent's progress in broader terms and value your participation in their counseling experience.

## **Billing and Payment**

You will be expected to pay for services at the time services are provided, unless you have a different agreement with me or a different arrangement is required for third-party payment. Any outstanding balances will be billed monthly. I reserve the right to turn delinquent accounts over to a collection agency in order to collect unpaid balances. In most collection situations, the only information that would be released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such action is necessary, its costs will be included in the claim.

## **Insurance Reimbursement**

I do not work with Insurance networks, but I can provide a Superbill that you can provide your Insurers for reimbursement.

I look forward to our work together and highly encourage your feedback as we collaborate on your specific therapeutic goals.

Your signature below indicates that you have read, understand and agree to the Therapy Policies of Carrie Wilkerson Healing and that you have received a copy of these policies.



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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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