KRYSTAL
HERNANDEZ-KANE

PSYCHOLOGIST, LLC

Krystal Hernandez-Kane, Ph.D.
670 Meridian Way, Ste 148, Westerville, OH 43082
Phone: 614-964-4545 Fax: 614-964-4546 Email: khernandezkane@protonmail.com Website: drkrystalhernandezkane.com

Professional Services and Informed Consent

Welcome to my practice. This document outlines information about my professional services, business policies, informed consent, and the nature of confidentiality. These details are critical as you make decisions about your treatment, and we collaborate on your goals and expectations for therapy. As a member of the *Ohio Psychological Association* and *American Psychological Association*, I adhere to their ethical principles and code of conduct, as well as their guidelines for continuing education so I may consistently provide ethical and evidence-based treatment. As a licensed psychologist, I also adhere to the laws and rules prescribed by the Ohio State Board of Psychology and the Ohio Revised and Administrative Codes.

Professional Services. In my practice, I provide therapy to adult individuals and couples. I am available to provide clinical consultation and supervision to clinicians-in-training and licensed clinicians as part of their ongoing professional development and growth. Additionally, I am available to provide consultation and outreach on a variety of mental health topics to schools, businesses, and other groups and organizations within the community.

Psychotherapy is a time-limited, focused process based on psychological theory, research, and treatment methods that addresses diverse psychological difficulties. Psychotherapy involves open, honest, and direct communication as well as a professional relationship between the therapist and the individual/couple/family. The goals of psychotherapy are to gain insight and understanding about yourself and what is important to you – values, relationships, short- and long-term goals – as well as effective coping skills to better address the psychological difficulties you experience. You may have heard that therapy "gets worse before it gets better." Often, clients' journey into their own thoughts, feelings, and behaviors as well as what they want to improve via therapy means they will feel challenged to grow, express strong emotions, address unpleasant experiences, unlearn negative patterns they have internalized, adopt healthier perspectives, and reframe how they interact with others and seek their needs and aspirations. In these ways, clients generally report psychotherapy is productive and beneficial. There are potential risks posed by psychotherapy, however, which may be currently unknown or unidentifiable, and vary widely among individuals; addressing some issues may be painful at times. I encourage you to share any concerns and questions you have about the therapy process, and we can discuss these concerns and how they may impact your ability and willingness to either initiate or continue treatment.

The Therapeutic Relationship. My relationship with clients is professional and therapeutic in nature. In order to maintain this relationship, it is important that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not "friend" or follow me on social media sites. If there is content from your online life you wish to share with me, please bring it to our sessions where we can explore it together. Ethical standards require that I do not socialize with my clients. However, there is a possibility we may see each other while out in the community; if we do see each other, you are welcome to acknowledge me and I will acknowledge you. However, I will not initiate contact nor engage in deeper conversation with you in order to best protect your confidentiality and privacy.

When providing therapeutic services, I am mindful of the ways in which clients may benefit from additional services and refer friends, relatives, partners, colleagues, and others to me when they find they are receiving helpful treatment. In these cases, I strive to be transparent and collaborative while maintaining necessary ethical and professional boundaries. With this in mind, I generally will not meet with you for concurrent services, such as for both individual and couple therapy. However, there may be circumstances that warrant a significant other(s) joining you for one or a few sessions of your

individual therapy. Similarly, when in couple therapy, it may be helpful to meet with each partner individually on a very limited basis, when it is clinically relevant and balanced. While I appreciate when you refer others for separate treatment to me, I am mindful of possible conflicts of interest should this be a person/relationship you have addressed, or want to address, in your own treatment. I cannot confirm nor deny whether another individual or couple is my client. If a conflict of interest arises, I will work with clients in ways that protect their confidentiality and discuss whether referral(s) to another provider(s) may be necessary. In summary, I strive to create a safe space for you to process openly your diverse feelings, concerns, and relationships.

Professional Disclosure. I graduated with a Ph.D. in Clinical Psychology from Bowling Green State University (2011) and I have been licensed as a Psychologist in Ohio since 2014 (P.7151). I am a member of several professional organizations, including the Ohio Psychological Association, American Psychological Association, and The International Association for the Excellence in Emotionally Focused Therapy. My theoretical orientation to therapy is integrative and individualized according to the specific client, combining primarily cognitive-behavioral and acceptance-based approaches, emotion- and solution-focused therapy, interpersonal, and humanistic and client-centered orientations. I am a certified Therapist in Emotionally-Focused Therapy for my treatment of couples.

Appointments. Appointments are usually 50-55 minutes in duration, with the exception of our first appointment (intake), which is generally 60 minutes. When we make an appointment, I reserve that time for you. If you cancel an appointment, please contact me to cancel *at least 24 hours before your scheduled appointment*. The charge for a late cancellation is $90. The charge for a missed appointment (no-show) is $120. Insurance will not reimburse for missed appointments. If you are late to a session, we will only spend the time originally allotted for your appointment. If we are scheduled to meet with you as a couple, I will not begin our session until all members are present. Please note that insurance may not reimburse for partial sessions.

Therapy requires your full presence. It is expected you arrive to a session fully clothed, sober, and alert, and do not consume or use related substances during your appointment. If you are intoxicated, you will be asked to leave and will be charged for the full session personally, as I cannot bill your insurance under these circumstances.

When meeting virtually for appointments, it is expected that you attend session in a place that is quiet, well lit, confidential, and free from distractions (including cell phone or other devices). You will arrange for childcare for any children in the home. You will not attend session while driving or otherwise occupied by another task. If this meeting requires the involvement of more than one person, all people will need to be visible on the same computer screen throughout our appointment. Please make sure your internet and computer is set up with a camera, and has adequate bandwidth as well as sufficient picture and audio quality. You will use a secure internet connection rather than public/free Wi-Fi.

Fees. A thorough understanding of payment policies is essential to both of us accepting our responsibilities and in enhancing therapeutic progress. Payment problems can negatively impact your experience of treatment. I have listed my fees for services below.

My fee is $220 for the initial therapy intake appointment (for individual and couple therapy).

Individual therapy. The fee for each subsequent session of individual therapy that lasts up to 52 minutes is $170. Individual therapy sessions that are 53-60 minutes (this is how insurance reimburses for appointments based on duration) are $180 a session. If you elect private pay and arrive late to session, you will be charged the full fee.

I generally do not provide formal psychological testing. If I do administer and score psychological tests, they will be billed according to the test(s) given, and the associated rates will be provided to you before testing.

Couple therapy. The fee for each subsequent session of couple therapy is $185. If you choose to use insurance for couple therapy, the client who decides to use their insurance will be considered the "identified client" and must have a diagnosis

in order for insurance to provide coverage. If you choose to pursue private pay for couple therapy, a diagnosis of any one partner is *not* required. Additional policies are explained in a separate *Couple Therapy Consent Form*.

Family therapy. On occasion, I may meet with adult family members together for therapy. The fee for each subsequent session of family therapy is $185. If you choose to bill insurance for family therapy, the client who decides to use their insurance must have a diagnosis in order for insurance to provide coverage. If you choose to pursue private pay for family therapy, a diagnosis of any one family member is *not* required, and if you have insurance you will have to pay for the session at the time of the session.

Minors and Parents. Only in very limited circumstances will I meet with clients under age 18 for family therapy. Clients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records. Ohio law allows children between 14 and 18 to independently consent to and receive up to six sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed without the child's agreement, except where there is potential danger to the child. While privacy is especially important to teenagers, and us all, parental involvement is also essential to successful treatment. For children 14 and over, I will request an agreement between my client and client's parent(s) allowing me to share general information about the progress of the child's treatment and the child's attendance at scheduled sessions, although the parents may later decide to revoke their consent to this agreement. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel the child is in danger, whether themselves or another person, in which case I will notify the parents about my concern. Before disclosing information to parents, I will discuss this with the child, if possible, and do my best to handle concerns the child may have. Based on the federal laws under HIPAA guidelines, parents have the right to examine the complete Clinical Record, including Psychotherapy Notes from their child's therapy. A parent may put this request in writing to me, and I will likely discuss this request with the child as well as the parent(s) before honoring it, as it could jeopardize the child's ability to trust me as well as be open and honest in their treatment. Information will not be shared in the case of divorce or separation where a court order exists which blocks the releasing of information to a non-residential parent.

Consultation and Outreach. I am available to provide consultation and outreach on a number of topics related to mental health, psychology, and clinical training. My fees depend on the nature of the request, the duration of the consultation/outreach, and the level of preparation needed to fulfill your request. I will ask that you sign a separate agreement that includes additional details. I am *not* available to provide consultation and outreach if you are also a therapy client of mine.

Supervision. I have significant experience providing supervision to all levels of clinicians, from unlicensed trainees, doctoral psychology interns, postdoctoral fellows, and licensed clinicians seeking additional supervision or consultation. If you are seeking supervision, my fee is $140 per hour of supervision. You are strongly encouraged to record (audio or video, with client consent) your sessions with your clients to review in our supervision sessions. I will ask that you sign a supervision agreement that includes additional details, such as the goal(s) of supervision, duration of supervision, and whether additional clinicians/training directors/supervisors/bosses need a summary or evaluation of supervision. I am *not* available to provide supervision if you are also a therapy client of mine.

Other Services. There is generally no charge for brief, informational phone conversations when deciding to pursue treatment and between scheduled therapy sessions. Consultations made on behalf of the client *over* 15 minutes in length with the client, or other professionals and agencies will be charged at $5 per minute rate and billed per minutes following the first 15 minutes. Charges may be made for telephone calls with you when the call becomes part of the therapy and is not informational. These fees *cannot* be submitted to insurance.

If it is necessary for me to complete paperwork/forms, write letters, or engage in extensive consultation with other professionals or agencies that last more than 15 minutes, you will be billed at the rate of $45 for each 15 minutes or fraction thereof. These fees *cannot* be submitted to insurance.

Payments. *Insurance.* It is important for all clients using insurance coverage for sessions to take the responsibility to confirm with the respective insurance company the specific coverage for mental health treatment. If you choose to use insurance, your responsibilities include payment of your *full co-pay at the time of service,* all services *not* covered by insurance, your deductible at the beginning of your benefit year, forwarding to me any insurance checks you receive, and being aware when your benefit year begins and ends. You understand that any phone verification of insurance benefits completed cannot be considered fully reliable, and sometimes coverage can be confirmed and later denied. You are responsible for filing complaints or suits against your insurance company if they deny payment or delay payments unreasonably on an eligible visit.

If you provide me with your insurance information and sign the *Billing Information and Authorization* form, my office will file your insurance claim. If you do not provide me with the insurance information and do not sign on the signature page, you must inform me that you do not want me to file any claims with your insurer, even if I am an in-network provider and you pay for the session at that time. While using your insurance benefits can be cost effective, the consequence of doing so means my office is required to disclose some basic information to your insurer, including your diagnosis. Your insurance retains the right to audit my records, as indicated in your insurance contract with your insurance company. They may also request updates regarding your treatment and progress, and at times copies of your Clinical Record, in order to authorize additional sessions. I will make every effort to release only the minimum amount of information about you that is necessary for the purpose requested by your insurance. Because insurance companies will often collect and store information online, please be aware of their own policies regarding confidentiality; I do not have control over what an insurance company does with your information, and your information may be included in a national medical information databank which could affect your ability to obtain different types of insurance in the future. Signing the consent to submit claims to your insurance company means you understand this choice. This decision is your privilege. I will provide you with a copy of any report I submit, if you request it.

All co-pays and deductible amounts must be paid *at the beginning of each visit* unless special arrangements have been made before the scheduled session. If your insurance is denied, regardless of the reason, you will be held responsible for any charges. Health Savings Account (HSA) or Flexible Spending Account (FSA) funds may be used for making payments for sessions. You agree to be fully responsible for paying all services rendered which your insurance denies.

Your insurance company is legally responsible to pay your bill within 30 days of my submission of your claim. It is your responsibility to maintain contact with your insurance company if they do not pay on this schedule. You remain responsible for your bill until your insurance company pays the agreed upon balance of the fee or in the event they refuse to pay this balance.

Private Payment. Using health insurance benefits requires disclosure of information to your insurer. You have the right to elect to pay privately for services and retain your rights of privacy, and if you elect this option you have to do so prior to each session and pay for the session in full. It is your responsibility to determine whether HSA or FSA funds can be used if you elect private pay. I will not send any information to your insurance company.

Delinquent Account. I reserve the right to withhold scheduling additional appointments until outstanding balances are paid, which is intended to help maintain our professional relationship and agreement, and limit the possibility that therapy becomes more stressful than helpful to you.

If your account is delinquent for more than 60 days and arrangements for payment have not been agreed upon, I have the option to discontinue therapy and/or use legal means to secure payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise limited confidential information and you agree to allow me to do that by signing below.

Payment Methods. I accept credit/debit cards, cash, and checks for services. Checks should be made payable to "Krystal Hernandez-Kane, Psychologist, LLC." There will be a $25 fee for returned checks. Replacement of any returned check and any additional charges accrued must be made with a money order, cashier's check, or cash. If a bill from my office

must be resubmitted the following month due to lack of payment, a $5 re-billing charge will be posted for each month this is necessary. If a session is not covered by insurance, you are responsible for payment at the time of service.

Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and protects client rights regarding the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a *Notice of Privacy Practices* for use and disclosure of PHI for treatment, payment, and health care operations. The *Notice* explains HIPAA and its application to your PHI in greater detail and is included in your intake packet. When you sign this document, it will represent an acknowledgment that you have received this *Notice*.

Confidentiality. I provide a summary here of confidentiality and its limitations. It is imperative you read and familiarize yourself with the *Notice of Privacy Practices* that you received for more detailed explanations, and that you discuss with me any questions or concerns. Laws protect the privacy of all communications between a client and therapist. Any individual employed by me in my office will receive training about HIPAA and protecting your privacy, and will be required to not release information outside of the practice and its responsibilities discussed here. In most cases, I will release information about your treatment to others only when I receive your written authorization, which is form that meets legal requirements according to HIPAA and the State of Ohio. There are some instances in which I am required to disclose information either with or without your consent or authorization. These are listed below:

- If you are involved in a court proceeding and a request is made for information about your treatment, I cannot provide such information without your written authorization or a court order. If you are involved in or considering litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information. I discourage clients from subpoenaing me for any reason.

- If a government agency is requesting information about your treatment, I may be required to provide details and records about your treatment.

- If you present a claim or lawsuit against me, I may disclose relevant information about you in order to defend myself.

- If you present a worker's compensation claim, I may be required to provide a copy of your records or a report of your treatment.

In addition, there are instances in which I am legally obligated to take actions to attempt to protect yourself and others from harm, and in such cases I may reveal some information about your treatment with or without your consent. If such a situation arises, I will make every effort to inform you before taking any action and disclosing information, if I believe this is appropriate, and will limit what I disclose to only that which is necessary. For example:

- If I believe you present a direct and imminent threat of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members or trusted others, seeking hospitalization for you, contacting the police, and notifying any potential victim(s).

- If I have reason to believe a child, an elderly adult, or a developmentally or physically challenged or dependent adult is being abused or neglected, the law may require me to report that information to the appropriate state or local authority/agency.

Emergency Services. I do not provide emergency services. All phone messages and emails will be checked daily unless otherwise stated, but are not for use in an emergency. In a medical or psychological emergency (24/7), you are advised to call 911 or go to your nearest emergency room. I have listed some local resources:

Mt Carmel St Ann's Hospital
500 South Cleveland Avenue, Westerville, OH 43081
Emergency Department: 380-898-4400. Main Number: 380-898-4000

OhioHealth Riverside Methodist Hospital – Emergency Department
3535 Olentangy River Road, Columbus, OH 43214
614-566-5000

Ohio State University Hospital – Emergency Department
410 West 10th Avenue, Columbus, OH 43210
614-293-8333

The following are national resources and hotlines, many of which have the ability to help connect you to local resources:

Crisis Text Line: text "4HOPE" to 741741, available 24/7, https://www.crisistextline.org

SAMHSA's National Helpline: 1-800-662-HELP (4357), available 24/7

988 Suicide and Crisis Lifeline: dial 988 to connect to the National Suicide Prevention Lifeline

The Trevor Project: 1-866-488-7386, thetrevorproject.org

When you enter treatment, you agree to the following conditions:

You agree that I may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely fashion as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In these instances, only the minimal amount of required information will be released.

You agree that I may need to consult with my practice attorney regarding legal issues involving your care, which is typically an infrequent occurrence but may happen from time to time. My practice attorney is bound by confidentiality rules. I will reveal only the minimum information necessary in order to receive relevant legal advice in connection with these contacts.

I may consult with other mental health professionals and employ administrative staff. In most cases, I need to share protected information with these individuals for both clinician and administrative purposes, such as scheduling, billing, and quality assurance. If I do so, I will release only the information necessary in order for me to provide quality services to you. I will obtain your written permission to consult with any mental health professionals outside of the agency, for example to coordinate or transfer treatment. All of the mental health professionals are bound by the same rules of confidentiality.

I may have a contract with a billing service. I will have a formal HIPAA business associate contract with this business, in which it agrees to maintain the confidentiality of data except where release of certain information is allowed in the contract or required by law.

I may have a contract with a collection agency. I will have a formal business contract with this business, in which it agrees to maintain the confidentiality of data expect where release of certain information is allowed in the contract or required by law.

Professional Records. The laws and ethical standards of my profession as a psychologist require that I keep PHI about you in your client file, also known as your Clinical Record. Your record may include information about your reasons for seeking therapy, a description of the ways in which your concern(s) affect(s) your life, your diagnosis, the goals for treatment, your progress toward these goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records I may receive from other providers, reports of any professional

consultations, any payment and billing records, any records of written correspondence between us, and copies of any reports or letters that have been sent to anyone (including to your insurance carrier). You may examine and/or receive a copy of all of your records if you request them in writing, unless I determine, for clearly stated reasons, that disclosure of the records to you is likely to have an adverse effect on you, and in that event I may exercise the option of turning over the records to another mental health professional designated by you. Because these are professional records, they can be misinterpreted and/or unsettling to untrained readers, I recommend that you initially review them with me or have them forwarded to another mental health professional to review and discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will inform you about the charge(s) at the time you request records. If you want information sent to you electronically, if I maintain the information in an electronic format, I will provide the information in that format if you agree to accept the potential risks involved in sending information electronically.

As your psychologist, I may also keep a set of Psychotherapy Notes which are for my own use and designed to assist me in providing you with the best treatment. While the contents vary among clients, they may include the contents of our conversations, my interpretation of these conversations, and how they impact your treatment. These notes are kept separate from your Clinical Record. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. Insurance companies cannot require your authorization as a condition of coverage and cannot penalize you for your refusal. I will discuss with you whether or not I maintain Psychotherapy Notes on you.

If a form needs to be completed as part of our agreement with your insurance company, there will be no charge for the report.

Legal Matters. I prefer not to testify in legal proceedings. However, if I become involved in legal proceedings that require my participation, as a result of my treatment with you, regardless of who involves me, a fee will be charged for my professional time. I will request that a retainer be paid for half of the expected fees at least one week prior to providing these services, and the second half of the expected fees and any additional costs accrued be paid within one week of service delivery. Any unused amounts will be refunded. My professional time for legal proceedings may include preparation (e.g., document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time I wait in court prior to or after I may be called to testify. Due to the time consuming and often difficult nature of legal involvement, I charge $350 per hour for these services. You will be responsible for any legal fees I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Service and Emotional Support Animals. My office lease prohibits animals from coming into the office. There may be some exceptions should you have a Service Animal, which by law the property manager is required to accommodate. However, please note that you will be financially responsible for *any and all* pet accidents, including stains or destroyed furniture, that occur; your bringing your Service Animal to our appointment acknowledges your agreement to this condition. In addition, I do not write letters of support for Emotional Support Animals. I do not have knowledge or training to appropriately assess and certify your animal, even when you have demonstrated your ability to be responsible for an animal.

Change of Personal Information. Please inform me, as soon as possible, when you change your home and/or work address, telephone number(s), email address, name (including pronoun usage), health status, employment status, marital status, or insurance carrier during therapy. I must maintain accurate and up-to-date records. I encourage you to discuss any pending changes in your insurance coverage prior to making a change, as it may affect coverage and your financial obligations to me.

Email, Texting, and Electronic Communication. I prefer to not text clients, unless in cases of emergency where I am otherwise unable to reach you, and do not use email or electronic communications unless we both agree that it is appropriate. If you decide you want to utilize any form of electronic communication, you acknowledge there are

confidentiality risks inherent in such communications if they are unencrypted, and you agree to accept those risks by signing below. There may be some exceptions should I utilize an online, HIPAA-secure scheduling/record system, which may provide the opportunity for you to consent to receive text reminders of your appointments or to schedule your appointments online. If this is the case, I strongly encourage you to be aware of any electronic device and related safety precautions when using a website that contains your personal information related to your treatment. When we do utilize email to communicate, for example about scheduling, I will utilize a HIPAA-secure email address for any necessary communications.

Social Media. I explained above that I do not "friend" or follow clients on social media in order to respect and maintain confidentiality and the therapeutic relationship. Additionally, it is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis, if I have reason to suspect you are a danger to yourself or others, and I have exhausted all other, reasonable means to contact you and/or your designated emergency contact, then I may use a search engine for information to ensure your welfare. If this were to occur, I will document fully my search and discuss with you at your next session.

Please be aware if you use location-based services on your mobile phone, as you may compromise your privacy while attending sessions at my practice. My office can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a therapy client due to any regular check-ins you may make at my office location.

Incapacity or Death of Therapist. In the event I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form, you consent to allow another licensed mental health professional whom I designate to take possession of your file and records, provide you with copies upon request, or deliver them to a therapist of your choice.

Inclement Weather. In the event of inclement weather when meeting in-person, please note the posted Levels of Emergency for your residential area and that for the office (Delaware County). If there is a Level 1 Emergency, you can expect that we will continue to meet for our scheduled session. If there is a Level 2 Emergency, you can expect that I will reach out to you to determine whether we both may safely make it to our scheduled sessions. In the event of a Level 3 Emergency, you can expect that we will not meet in-person for our scheduled session and I will be in contact with you to confirm this. If I need to cancel a session based on my inability to travel to the office in a weather emergency, or if we cancel due to a Level 2 or 3 Emergency, you will not be charged for the cancellation.

Credentials. Dr. Krystal Hernandez-Kane is licensed as a psychologist in the State of Ohio (Ph.D.), License P.7151. You may verify these credentials at https://elicense.ohio.gov/oh_verifylicense.

Questions. Please discuss with me any questions you have about this document, including office policies, payment procedures, informed consent, confidentiality, and your rights as a client.

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize Dr. Krystal Hernandez-Kane to provide such care, treatment, or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third-party payer to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through Dr. Hernandez-Kane at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this *Acknowledgment of Informed Consent to Treatment*, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to ask questions and seek clarification of anything unclear to me. If a minor or an adult with a court appointed guardian is the client, I am signing on behalf of the minor or ward as the authorized parent/guardian. (Information on Minor rights will be shared with the minor or ward as appropriate.)

I acknowledge that I have received a copy of the *Notice of Privacy Practices* for Dr. Krystal Hernandez-Kane.

Client Name(s) (please print)

_____

_____

Client Signature(s)

_____ **Date** ___/___/_____

_____ **Date** ___/___/_____

Parent(s) or Guardian Signature (for minor child, children, or disabled adults)

_____ **Date** ___/___/_____

_____ **Date** ___/___/_____