Katie McBride, Ph.D.

Licensed Psychologist

6000 Brownsboro Park Blvd. Ste. G Louisville, KY 40207

[km@katiemcbridephd.com](mailto:km@katiemcbridephd.com)

Phone (502) 523-8871

### CLIENT INFORMATION FORMA

##### Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street City, State Zip Code**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile Home/Alternate**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May I contact you Emergency Contact Person**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On mobile phone? YES / NO Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By email YES**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_**

**Social Security # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Years of Education completed: \_\_\_\_\_\_ Occupation : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*If a referring professional, do I have your permission to thank this person/practice?**

**Yes \_\_\_\_\_\_\_\_\_\_ No/Not at this time\_\_\_\_\_\_\_\_\_\_**

**Initial Initial**

**Cancellation Policy: Twenty-four hours notice is required for cancellation of appointments. With exception for illnss, you will be charged the FULL FEE for any failed appointments or cancellations without twenty-four hours notice. Most insurance plans will not cover this cost.**

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Consent for Treatment

I hereby give consent for receipt of services for myself and/or my child(ren) from Katrina A. McBride, Ph.D. I understand that treatment outcomes vary, and that I will be involved in the ongoing formation of evaluation and treatment goals.

I understand that psychotherapy can be a difficult process and that painful emotions may likely arise during the course of treatment. I understand that Dr. McBride’s role is to help me or my child or family work toward some resolution of these painful feelings associated with the life events that have led to treatment.

I understand that treatment and information related to evaluation and treatment is confidential and that my therapist cannot release treatment information without written consent.

I understand, however, that there are exceptions to this right to confidentiality and that Dr. McBride is legally obligated to contact relevant authorities in cases of 1) past or present, suspected or confirmed child neglect, physical abuse, sexual abuse; 2) violence between spouses or domestic partners; and 3) when a client shows intent to harm self or to kill another person. I understand that Dr. McBride will make every reasonable effort to obtain prior consent and keep me informed of any necessary breach of confidentiality.

I understand that a judge may order the release of records and/or compel Dr. McBride’s testimony about my and/or my child’s treatment or evaluation. I understand that McBride will make every reasonable effort to protect my confidentiality, to obtain prior consent, and keep me informed of any necessary breach of confidentiality.

* I understand that to promote a high quality of care, confidential case consultation (i.e., sharing case information without identifying information such as names) may occur between Dr. McBride and qualified colleagues.
* Dr. McBride has part-time office hours, and a mobile phone and encrypted email are used as primary communication. REGULAR TEXTING IS NOT A SECURE FORM OF COMMUNICATION, and is used in very limited ways.
* Dr. McBride may not be immediately available by phone, text or email, and that in such cases, emergencies are to be managed through the local crisis line [(502) 589-4313] or 911.

# By signing below, I acknowledge the above information and provide consent for treatment for myself and/or my child. I also acknowledge that I have received a copy of this consent. Additionally, I have received a copy of Psychologist-Client Services Agreement, which includes a Notice of Privacy Practices for this office.

Client/Guardian Date

#### Guardian Date

Katie McBride, Ph.D.

Licensed Psychologist

**Credit Card Authorization Form**

**(Debit, Health Savings Account, MasterCard, Visa)**

Client Name:

Parent/Guardian Name (if client is a minor):

I authorize Katie McBride, Ph.D., PLLC, to keep my signature on file and to charge my therapy session payments or other fees incurred ({Please refer to Dr. McBride’s **Fee Schedule** for detail: e.g., phone consultation, collateral sessions, chart/report review, electronic communication, court preparation, testimony) to the credit card selected below. Credit card authorization forms will be kept confidential. I understand there is a $5.00 fee for all cards that are declined.

I understand that my credit card will be charged as follows:

At time of session and to satisfy all charges incurred to date

OR

Bi-monthly at a rate of $ until balance is paid in full. Interest will be charged for balances more than 30 days past due.

Visa® MasterCard®

Credit Card Number: Expiration Date:

3-Digit PIN# on back of card:

Exact Name on Card:

Billing Address for Card:

City, State, Zip:

Email address to send receipt:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed and understand the terms of the credit card authorization, and I give my permission to charge my credit card accordingly.

Signature of Cardholder: Date:

Phone Number of Cardholder:

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**Financial Agreement**

I understand that I am financially responsible for the payment of all charges rendered to me, or to any members of my family. I understand that all fees are to be paid at the time of each visit unless other arrangements have been made with Dr. McBride prior to receiving services.

I understand that Dr. McBride does not participate on insurance panels, and that any coverage my insurance company may provide will be on an out-of-network basis. I understand that I may request forms from Dr. McBride that may be submitted to my insurance claims office for reimbursement according to my out of network insurance coverage. I understand that it is **my responsibility** to obtain any necessary pre-approval or pre-certification from my insurance company, and that I will be charged for time that I request Dr. McBride to invest regarding my insurance coverage.

I understand that travel time for any off-site visit that my therapist makes at my request will be billed on the basis of Dr. McBride’s designated hourly rate. I understand that if I compel Dr. McBride to testify in court, **I will be billed at the forensic hourly rate**, including preparation and travel time. I further understand that any time for phone, email, letters, recommendations, and record review will be billed at the designated hourly rate, and that emails are billed per occurrence as well as in time (See Rate Schedule).

I understand that the **full fee** will be charged for missed appointments and appointments that are cancelled within **twenty-four (24)** hours notice (excepting serious illness). (\*\*These fees are not typically be reimbursed by insurance.)

**I understand that account balances with no payments for sixty days may be forwarded for collection action, and that unpaid monthly balances will accrue interest at the rate of 3% per month.**

**I have read and agree to the above statements.**

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

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

#### Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND SERVICE AGREEMENT

You have been given a notice (“PSYCHOLOGIST-CLIENT SERVICES AGREEMENT”) that describes how health care information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

All requested information shall be relevant to the care and well being of the individuals served. All information should be considered Protected Health Information (PHI), in accordance with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Your signature shall serve as acknowledgment that the office of Dr. McBride may use and share information for treatment, payment, and business office operations. The use or sharing of any information shall have prior written authorization, unless exempted by law (such as in cases of life threatening emergencies or child endangerment).

**Rights of the Individual**: The individual may request, in writing, restrictions on the use or sharing of information, receive confidential communication, inspect and receive copies of any shared information, receive an accounting of shared information, request to amend their information, or revoke authorization.

**Responsibilities of this office**: Maintain privacy and provide notice of legal duties and privacy practices, abide by this effective notice and any restriction agreements, provide notice of revised privacy practices.

For additional information or complaints, please speak with Dr. McBride.

Complaints against this office regarding privacy of PHI should be forwarded to:

## Office for Civil Rights

## U.S. Department of Health and Human Services

#### 200 Independence Ave., SW Room 509F

#### HHH Building

#### Washington, D.C. 20201

1-800-368-1019

This notice has been issued and considered effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This copy shall be retained by this office for a minimum of seven (7) years.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Relationship to client

(Client or guardian)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

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# Psychologist-Client Services Agreement

## Notice of Privacy Practices

This document contains important information about professional services and business practices. It also contains information about the Health Information Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information. **Although these documents are long and complex, it is important that you read them carefully.** You are welcome to ask Dr. McBride for clarification at any time.

HIPAA requires that you be provided with a Notice of Privacy Practices. This document explains how this office may use and disclose your protected health care information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information**. “Protected Health Information” (PHI) is information about you that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.**

This office is required to abide by the terms of this Notice of Privacy Practices. This office may change the terms of the notice at any time. Upon your request, you will be provided with any revised Notice of Privacy Practices. When you sign this document, it will represent an agreement between you and this office. You may revoke this agreement in writing at any time. That revocation will be binding unless action has already been taken, or if you have not yet satisfied any financial obligation you have incurred.

Under most circumstances, Dr. McBride is required by law to obtain your written permission for any disclosure (electronic, written, or oral communication) of identifying information about you and your treatment. If you and Dr. McBride believe that communication with a third party (for example, previous psychotherapists, physician, school personnel, court system), you will be asked to sign a release of information to that effect.

## Psychological Services

### Psychological Treatment

Psychological treatment services of this office include individual adult psychotherapy, individual child therapy, family therapy, parenting support and consultation, and couples therapy. I may refer you to additional services (e.g., medication evaluation, group therapy, psychological testing) if I believe this to be beneficial or necessary to your therapy here. You will be involved in the ongoing formation of evaluation and treatment goals.

Psychotherapy has the potential for both tremendous benefits and some risks, and length of treatment and outcomes do vary. Psychotherapy often significantly **reduces** emotional pain, confusion, and problems that interfere with successful relationships. Psychotherapy often leads to benefits such as improved relationships, solutions to specific personal and family problems, and increased motivation, energy, and focus. Psychotherapy, however, can be a difficult process and painful emotions (such as sadness, worry, guilt, anger, frustration) may likely arise during the course of treatment. My role is to help you, or your child or family work toward resolution of these painful feelings. We will work together to work past the discomfort associated with the life events that have led to treatment.

The first couple of sessions will be focused on gathering necessary information, and evaluating your needs. I will give you some impressions of what the work will include, and the kind of therapy approach I believe will best suit the problems you identify.

After the first couple of sessions you should evaluate your overall comfort level with my style and approach to therapy, as well as the recommendations you hear. If you have any questions about my approach or any of my procedures, I urge you to discuss them with me. I understand that professional styles differ, and if my style does not appear to be a good match for you, I will be very open in assisting you with a referral to another clinician.

### Forensic Services

I also provide forensic services for families, which means directly involved with court or officers of the court (e.g., attorneys). Written, verbal, and/or in-person contact with the legal system (e.g., Family Court) is expected. Divorce coaching, development and maintenance of co-parenting plans, and court-ordered evaluation sessions are examples. If you are already engaged in therapy with me, and you need such services, you will be referred to another specialist, as I cannot be in two different roles with you. If you are interested in such services instead of pursuing therapy, please speak with me about whether that may be a better fit with your needs. These services are typically not covered under health insurance plans, and are billed at a different rate than therapy services.

## Limits of Confidentiality

Treatment and information related to evaluation and treatment is confidential and treatment information cannot be released by a clinician without written consent. There are some circumstances, however, that require Dr. McBride to disclose your protected health information (PHI) without your consent. **Dr. McBride will make every reasonable effort to protect my confidentiality, to obtain prior consent, and keep me informed of any necessary breach of confidentiality.**

* If an adult is living in a relationship that is violent, Adult Protective Services may need to be contacted (If APS is contacted, that agency will simply contact the target of the violence and ask whether s/he would like support services from APS).
* If the client is at imminent risk for suicide, Dr. McBride is required to ensure that the client is evaluated immediately for inpatient treatment. This may involve communication with medical personnel, psychiatric staff, or even police/EMS personnel if necessary to ensure the client’s safety.
* If the client seriously threatens to kill another person or persons, Dr. McBride is required by law to warn intended targets, to contact law enforcement, and to ensure that that the client is evaluated immediately for inpatient treatment.
* If a client reports or shows signs of child neglect, physical abuse, or sexual abuse, Dr. McBride is required by law to ensure that a report is made to Child Protective Services**. This requirement extends to past or present, suspected or confirmed** abuse and neglect.
* In some case, sexualized contact between minors must be reported to appropriate agencies, depending on the type of contact, and the ages of the minors involved.
* Per federal statute, there may be limitations on the disclosure of information to parents of minors pertaining to substance use/abuse.
* A judge may order the release of records and/or compel Dr. McBride's testimony about treatment or evaluation.
* If a patient files a complaint or lawsuit against Dr. McBride, relevant information about the patient will be disclosed in order to defend or protect herself and her practice.
* If a patient files a worker’s compensation claim, and an appropriate request is made to this office, relevant information about the patient’s treatment must be disclosed to appropriate parties, including the patient’s employer and/or the worker’s compensation insurer.

Office Practices and Procedures

* To promote a high quality of care, confidential case consultation may occur with qualified colleagues. Identifying information (such as names, revealing occupations or positions) is not used. These colleagues are also bound to keep this information confidential. I will not advise you of these consultations unless I feel that it is important for you to be aware of this. I will note consultations of this nature in your clinical record.
* I have part-time office hours, and a mobile phone and encrypted email are used as primary communication. I may not be immediately available by phone, email, or text,, and that in such cases, emergencies are to be managed through the local crisis line [(502) 589-4313] or 911. REGULAR TEXTING IS NOT A SECURE MEANS OF COMMUNICATION, and is used on a very limited basis. I encourage all clients to download and use SIGNAL, an encrypted texting app.
* Your PHI with third party business associates that perform activities such as billing and accounting services for the practice. Whenever an arrangement is made between this office and a business associate that involves disclosure of your PHI we will have a written contract that contains terms that will protect the privacy of your PHI.

**Payment**

**Due to concerns about insurance companies’ interference in treatment services, and their demands for increasingly detailed confidential information, I do not participate on any health insurance plans.** This means that full payment of service is collected at the time of service (each session is paid for at the time of session). Most insurance plans will reimburse fees at an out-of-network rate, should you choose to file for reimbursement. You may receive a “superbill” from me that contains all necessary information to file for this reimbursement. **You should contact your provider to identify whether any pre-authorization is required before qualifying for this coverage.**

* If you are being seen through Workers’ Compensation, or have arrangements for payment through any 3rd party, you will be asked to sign a release of information to that organization for purposes of authorization of sessions and payment. Examples of information **required** by Workers’ Comp to approve and pay for services include **your name, diagnosis, treatment plan, prognosis, and notes that document your progress in treatment**.
* If individual client accounts are left unpaid for more than 90 days, necessary information such as your name, social security number, birthdate, addresses and phone numbers, and attendance in treatment may be given to a collection service for purpose of collection.

**YOUR RIGHTS**

**Professional Records**

This office develops and maintains written record of your treatment, which includes session notes, financial records, and any reports or letters to/from third parties. Pusuant to HIPAA, you have the right to examine and obtain a copy of your record. (\*There are unusual circumstances that would except this right, such as those that would involve danger to yourself or others, or if your record makes reference to another and it is believed that access to the record will result in substantial harm to the other person.) You are entitled to one free copy of your record. Any additional copies will incur a charge of $1 per page for copying and handling.

You may request an amendment of your record set. In some cases, your request may be denied. If your request is denied, you have the right to file a statement of disagreement. If you have any questions about amending your medical record, please feel free to discuss these with Dr. McBride.

You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as this office maintains the PHI. The record set contains medical and billing records about your treatment.

COMPLAINTS

All requested information shall be relevant to the care and well being of the individuals served. All information should be considered Protected Health Information (PHI), in accordance with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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#### 200 Independence Ave., SW Room 509F

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#### Washington, D.C. 20201

1-800-368-1019

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This notice became effective on January 1, 2012.

Katie McBride, Ph.D.

Licensed Psychologist

**RATE SCHEDULE**

**Psychotherapy:**

Initial Intake (60-70 min): **$300 ($295)\* \*cash/check discount**

45 min **$190 ($185)\***

60 min **$250 ($245)\***

90 min: **$375 ($370)\***

**Couples & Family therapy**

60 min **$265 ($260)\***

90 min: **$395 ($390)\***

**Hourly rate/60 min: $260**

(prorated $22 per 5 min) (billed for: phone time, texts & email, travel, report & letter review & writing)

**Executive Business Coaching & Consultation**

**&**

**Court-involved\*\* Clinical Services**

**$300** per 60 min.

**$450** per 90 min.

**Hourly rate/60 min $310**

Prorated $25 per 5 min. increments: (billed for time outside of session/meeting time): phone calls, e-communication\*, travel, report & letter review & writing, court preparation\*\*\*)

\*\*Note: For therapy sessions, you may be billed at the regular psychotherapy rate, even if you have some court or attorney involvement. If, however you have been referred by your attorney or the court and require related communication or recommendations **you will be billed at the forensic rate.** This session rate may shift back to regular therapy rates once the evaluation period ends, and monitoring recommendations are no longer required.

**With the exception of routine scheduling**, **each email or text received** **(including cc:’d)** will carry a charge of **$5.00.** Communication that requires a response and/or more extensive review will be billed at the hourly rate above, but with a minimum charge of **$20 per email**. revised November, 2023