

Kendra Twitty, LPC

Office: (843) 812-1018 Email: twittykendra@gmail.com

Notice of Privacy and Practice Policies

This notice describes how psychological and health information about you may or may not be disclosed to other parties: I may disclose your health information with your consent to a physician or therapist providing treatment to you or to obtain payment for services rendered to you.

You have the following rights concerning the use/disclosure of your health information: to request restrictions on certain uses/disclosures, to inspect and copy your information (excluding psychotherapy notes) and to request to amend any such information.

What is shared with me and any records kept regarding counseling sessions will be held in strict confidence. Clinical records of treatment will be securely maintained for at least the time frames required by law. Except for the following:

As required by law, I must disclose the following information without your consent or authorization in the following circumstances:

1. Child Abuse/Elder Abuse: If I have cause to believe that a child or elderly person has been, or may be abused or neglected, I am required to report this within a specified time frame to the proper authorities.
2. Judicial/Administrative Proceedings: If you are involved in a court proceeding which involves a court order requiring information about your diagnosis and treatment, I must release the requested information.
3. Serious Threat to Health/Safety: If it appears that you pose a serious threat to yourself or someone else, I may disclose relevant health information to medical or law enforcement personnel.

Counseling fees are \$120.00 per 50-minute session in office and \$150.00/ per 50-minute session of Equine Assisted Therapy and Learning. Fees are due at the time of the session. Cancellations made less than 24 hours in advance for non-emergency purposes are subject to 50% of session fee. **A no show with no notification is charged at the full hourly rate of the session fees above.**

I am committed to providing a safe and professional environment for our counseling relationship. As a client you may decide to end our counseling relationship at any time, although I do ask that you participate in a termination session. While benefits from counseling are expected, specific results are not guaranteed.

Your signature below indicates your understanding and acceptance of the above limitations on the confidentiality of your personal information and your agreement with the fee structure and charges described above.

Signature _____ Date _____