Kimberly Ann Malloy, M.S., LMFT,
#01228
Marriage and Family Therapist,
Executive Coach
CIO for Center for Relational Health – LV, LLC
8879 W. Flamingo Rd, Ste 101
Las Vegas, NV 89147
449-7593

Disclosure Statement

Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. It explains my therapeutic approach, services, fees, policies, and your rights as a client. Additionally, this disclosure statement provides you with information about my education, training, and experience. After you have read this statement, you will be asked to sign a statement of acknowledgement stating that you have received it and you will be provided a copy for your records.

Biographical Information: Welcome to my practice. My name is Kimberly Malloy. I graduated with a Bachelor of Arts in Communication from the University of Nevada, Las Vegas, and a Master of Science in Counseling from the University of Phoenix. I am currently registered with the State of Nevada as a licensed Marriage and Family Therapist (#01228) and an approved AAMFT Supervisor. I am a certified licensed instructor in the Hartman Personality and Character Profile, a Certified Daring Way™ and Dare to Lead™ Facilitator, which is based in the research of Dr. Brené Brown. I have owned my own corporate training and coaching company for 20 years and use my experience in this field with my therapeutic training/coaching.

I am a member of the American Association of Marriage and Family Therapy (AAMFT).

Therapeutic Approach: As a marriage and family therapist, my training has been from a systems perspective. Systems therapy works with the relationship and cycles of interaction between persons and the context of systems that may be affecting one's life. Issues such as gender, culture, and spirituality are also considered. During our first couple of sessions, we will set specific goals to accomplish based on your presenting concerns. I will gather data and we will work together to find solutions. I always attempt to work within the structure of brief therapy thus, goals are targeted to be met within 10- 12 sessions. I believe that therapy not only takes place in the therapy room, but also between sessions, therefore, a part of your therapeutic process may include assignments outside the therapy room.

Other Approaches:

While I have done training in the Gottman Method Couples Therapy, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.
I also use, as a technique, EMDR which is eye movement desensitization reprocessing, a type of therapy used for trauma. I will not do this without your verbal consent.

I work with individuals, couples, adolescents, families, and groups. The approaches that I use in treatment vary. I believe the relationship between the therapist/coach and the client is paramount for productive treatment and ultimately for healing to occur. Typically, treatment consists of:

1. An assessment, which may include any or all the following: interviews, observation, review of records, behavior rating scales, biological, psychological and social history, and/or mental health evaluation.
2. Development of a treatment/coaching plan, which includes goals and objectives, therapeutic interventions, and estimated length of treatment.
3. Implementation of treatment/coaching plan.
4. Ongoing assessment, discussion of progress, and revisions to the treatment/coaching plan as appropriate.
5. Completion or termination of treatment when satisfactory progress has been made or treatment goals are achieved.
6. Aftercare planning for follow-up care to maintain gains and prevent relapse if needed or desired by the client.

Appointments, Fees, Payment: As a therapist/coach in a private practice, I must operate as a small business. Therefore, I want you to clearly know the fees, payment and charges for my business. Sessions are 50 minutes in length and one session will be $175.00 and will be due at the end of each session. If you request a longer session, 75 minutes, the fee will be $260.00. Any time incurred due to court proceedings, which includes court preparation time, travel time, providing written documentation, and testifying will also be billed at the same session rate/ per 50 minutes. If I must travel these rates will be in addition at the same rate as stated. Partial hours will be prorated. Please note I do not bill insurance.

Your appointment is reserved particularly for you. If you are unable to make your appointment, please provide 24 hours' notice of cancellation by calling 702-449-7593. Failure to give 24 hours' notice of cancellation or failure to show up (No Show) for a scheduled appointment will result in you being charged your full session rate (rate listed above) and you will be expected to pay this fee at the start of your next session. Any outstanding monies owed will need to be paid before a future session may be booked. Please initial that you have read this section specific to cancellation of appointments: _____

Request for Additional Reports/Letters/Documentation/Legal Issues: Completing assessment paperwork, treatment/coaching plans, progress/psychotherapy case notes, brief phone calls and/or letters are included in your fee. However, if phone calls are frequent or extensive (longer than 15 minutes); if you require additional letters, reports, documentation; of if court attendance is requested, the charge will be based on the fee of $**250**.00 per 50 minutes, including travel and standing time.

Other Fees/Charges: You are responsible for all fees/charges incurred and will be billed for all charges not previously paid by you.

Insurance: I do not bill or accept insurance.

Refunds: No refunds are provided for services already rendered.

My Counseling clients:
Dual Relationships:
My professional code of AAMFT ethics and the Nevada statutes are very strict in terms of dual relationships. Due to this ethical code, all social networking sights would be considered a dual relationship. If we were previously on the same sight, please know I will no longer exchange any personal information with you via the sight and will not respond any longer to personal posts.

Technology:
All communication with my client may done in the therapy room/office, except for communications that needs to take place in reference to appointment scheduling, which can be done via text. At certain times I will accommodate my clients by using a tele-health program. Please note that my phone number is a cellular phone with a voice mail. My number is private as is my voicemail; however, the confidentiality of technology is beyond my control so please keep this in mind when communicating with me whether it is through email, texts or any tele-health program deemed appropriate at the time.
Tele-health sessions are available under some circumstances and again, the privacy of communicating in this form of technology cannot be guaranteed.

Tele-mental Health Services:
I hereby consent to engage in distance counseling/coaching with Kimberly Malloy, LMFT, as part of my psychotherapy or coaching, should she or I request it. I understand that distance counseling/coaching includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.
I understand that I have the following rights with respect to distance counseling:
The right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor rising the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical information also apply to distance counseling/coaching. As such, I understand that the information disclosed by me during my therapy/coaching session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine or tele-mental health interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from distance counseling/coaching, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of a HIPPAA-compliant service that is encrypted for video tele-mental health communications.

I understand that if my therapist/coach believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services, group therapy), I will be informed of such and we will either make the accommodation or be referred to a psychotherapist who can provide such services in my area.

I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.

Considerations:

It is important to note that there are limitations of distance counseling/coaching that can affect the quality of the session(s). These limitations include but are not limited to the following:

I cannot see you, your body language, or your non-verbal reactions to what we are discussing.

Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.

Technology might fail before or during the counseling/coaching sessions.

Although every best effort will made to reduce confidentiality breaches, breaches may occur for various reasons.

To reduce the effect of those limitations, I may ask you to describe how you are feeling, thinking, and/or actions in more detail than you would during a face-to-face session.

I have read and understood the information provided above. I have discussed it with my therapist/coach, and all of my questions have been answered to my satisfaction. _____ Initial

Counseling clients only:
Emergencies: If I will be out of town for a significant length of time, another therapist may be available for interim treatment. I will discuss this possibility with you before a prolonged absence. On some occasions I may leave contact information on my voice message for another therapist who will be available in my absence.
I do not operate a crisis center and therefore I am not available 24 hours a day, 7 days a week. Should you need this kind of therapy, please let me know upon reading this and I will provide you a referral to this kind of clinic.

Confidentiality: My professional code of American Association of Marriage and Family Therapist ethics and the Nevada statutes prevent me from disclosing information that is shared in therapy or releasing information without your written consent. If you are here for couples of family therapy, all persons involved in the therapy process are required to provide written consent before information can be released; however, I cannot guarantee the confidentiality of other participants who are involved in your therapy process. The only exceptions to confidentiality are stated in the family therapy section of this disclosure statement.

Your rights as a family therapy consumer:

1. To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (if known), and the fee structure provided.
2. To seek a second opinion. If needed, I can provide you with names of other qualified professionals.
3. To terminate therapy at any time without moral, legal, or financial obligations other than those already accrued.
4. To know that in a professional psychotherapeutic relationship sexual intimacy between the therapist and client is never appropriate.
5. To know that our therapeutic relationship is confidential except under the following conditions:
    a. If you threaten bodily harm or death to yourself or another person
    b. If you reveal information about physical abuse, sexual abuse or neglect in regard to a child or elderly person.
    c. If you are in court-ordered therapy.
    d. If a court of law issues a legitimate subpoena or a judge breaks your confidentiality.
    e. If you are under the age of 18, in the State of Nevada, parents have access to information regarding their child's medical records.
6. If you request, any part of your records can be released to any person or agency if you have signed an authorization for me to do so.

COUPLES:

Please be advised if you are attending couples counseling there may be a time where I request to see one or each of you individually, please know I am not the keeper of any secrets and whatever is exposed in an individual session, will be shared, at some point, in couple's session. I do not keep secrets.

_____

Both initials required if a couple

Minor Clients: If you bring a minor child to see me, by signing this disclosure you are stating you have the legal right to obtain treatment on behalf of said minor.

All marriage and family therapy services in Nevada are regulated by the Nevada Board of Family Therapist Examiners. Questions or complaints may be addressed to P.O. Box 370130, Las Vegas, NV 89134. The phone number is (702) 486-7388.

Acknowledgement

By signing below, I acknowledge that I have received a copy of Kimberly Malloy, MFT's/ExecutiveCoach disclosure statement.

AS well as agree that:

1. **I have read and understood the above policies.**
2. **I have read and understand the financial obligations and cancellation policies.**
3. **I have been informed of my therapist's credentials and my rights as a client.**

Signed: _____ _____

Client or parent/guardian ***please print*** **Date of Birth**

Signed: _____ _____

Client or parent/guardian ***Signature*** **Date**

Signed: _____ _____

Client or parent/guardian ***please print*** **Date of Birth**

Signed: _____ _____

Client or parent/guardian ***Signature*** **Date**

Refusal to Sign Acknowledgement

_____ _____

Client Signature Date

Therapist Signature

_____ _____

Kimberly Malloy MFT Date

Kimberly Ann Malloy MFT
702-449-7593

Consent to Treatment

As a client of Kimberly Ann Malloy MFT, I understand that:

1. I have the right to refuse any or all parts of the treatment plan, except for emergency treatment.
2. Consent to any or all parts of the treatment plan may be withdrawn at any time.
3. I will be informed of the nature, consequences and purposes of the treatment plan, and any alternative plans and resources available.
4. All counseling/therapy sessions are confidential other than the situations outlined in the disclosure statement.
5. As a client of Kimberly Malloy MFT, I have read my rights and acknowledge receipt of a copy of her disclosure statement.
6. I have been fully informed of the above, understood the process, and agree to accept such treatment and to cooperate in its implementation.
7. If I am bringing my minor child, I give Kimberly Malloy the right to treat my minor child and state I have the legal authority to request this treatment.

_____ _____
Client or Parent/guardian Signature Date

_____ _____
Kimberly Ann Malloy MFT Date