



**Dr. Peter R. Kilmann, Ph.D., M.P.H.**

Mailing: 10120 Two Notch Rd #16 Columbia, South Carolina 29223  
(803) 788-9243 • FAX (803) 736-0702 • [drpeterkilmann@aol.com](mailto:drpeterkilmann@aol.com) • [www.drpeterkilmann.com](http://www.drpeterkilmann.com)

Licensed Clinical Psychologist  
Licensed Marriage and Family Therapist

**BENEFITS**

Individuals or couples who choose to enter therapy often benefit from expressing their needs to a psychologist. They can often gain new perspectives, a clearer understanding of patterns and goals, and new skills. If you work with me in the sessions, and follow my suggestions and assignments, there is a greater likelihood that you will make the changes that are important to you.

**POSSIBLE SIDE EFFECTS OF THERAPY**

Seeking solutions and making choices to deal with troublesome life circumstances can sometimes lead to discomfort. Exploring unpleasant events can arouse frustration, anger and anxiety as well as lead to unexpected changes in existing relationships that might already be unstable. New awareness can sometimes foster temporary depressive feelings. Making personal choices that are best for your happiness can result sometimes in negative responses from those in your life who might resist your positive changes. Using mental health insurance may be detrimental to you in obtaining future health, disability or life insurance policies.

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**FINANCIAL POLICY**

*Please print your initials by each item to indicate you agree:*

- Dr. Peter Kilmann’s treatment/evaluation is **self-pay only** (only exception is Tricare members) with the fee to be paid in full before each session.
- Payment in full will be charged for cancellations with less than 48 hours notice.** We reserve time especially for you, so please call within 48 hours if you know you will need to reschedule your appointment.
- A charge of \$40.00 will apply for insufficient fund checks issued.

I have read and understand the financial policy. I agree to be bound by its terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Date

**INFORMED CONSENT SIGNATURE**

I acknowledge that I have received and read the attached “**To My Clients**” form. I further acknowledge that I consent to and seek treatment from Dr. Peter R. Kilmann. My signature below confirms that I understand and accept all the information contained in the “**To My Clients**” form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PLEASE, ASK QUESTIONS. IF YOU HAVE ANY QUESTIONS ABOUT MY QUALIFICATIONS OR ANY INFORMATION NOT ADDRESSED HERE, YOU HAVE A RIGHT TO A COMPLETE EXPLANATION.**

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*To My Clients:*

*To help you get the best possible benefits with the fewest possible side effects, you should be informed about your rights.*

- *You have the right to ask me questions about the therapeutic approach and methods that I use.*
- *You have the right to decide not to receive therapy from me. If you wish, I can provide you with the names of other qualified psychologists you may prefer to see.*
- *You have the right to end therapy at any time with no other financial obligations than those already accrued.*

## **CONFIDENTIALITY, SOUTH CAROLINA LIMITS OF CONFIDENTIALITY, HIPAA**

**HIPAA (The Health Insurance Portability and Accountability Act)** is a federal law governing mental health and counseling information records. It sets a national standard for patients' rights to confidentiality. In addition, **South Carolina's laws** related to mental health treatment are even more restrictive than HIPAA. HIPAA requires that I give you a Notice of Privacy Practices form which lists out the federal rules of confidentiality.

Confidentiality is one of your most important rights. Information you reveal during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission, with the very limited exceptions as required by South Carolina law.

In certain situations, the law requires me to reveal information obtained during therapy to other persons or agencies without your permission. I am not required to inform you of my actions in this regard. These situations are as follows:

- If you threaten grave bodily harm to yourself or another or death to another person, I am required to inform the intended victim and/or appropriate law enforcement agencies.
- If ordered by a judge to do so, I may be required to provide specific information from your file to the court.
- If you reveal information relative to child abuse and neglect, I am required by law to report this to the appropriate authority.
- If you are in therapy or being tested by order of a court of law, the results of the treatment or tests ordered must be revealed to the court.

All records are governed by ethical codes and standards of psychologists in the state of South Carolina. No information can ever be released from a client's records without proper legal compulsion. As defined by **South Carolina Law Section 19-11-95**, proper legal compulsion would be either consent from a client or a court order -- but not a subpoena unless the subpoena is issued by a, "duly constituted professional licensing or disciplinary board or panel". So, as a licensed clinical psychologist, I am under no obligation to respond to a regular subpoena from an attorney.

## **LENGTH OF THERAPY SESSIONS**

Sessions usually last forty-five (45) minutes. It is difficult initially to predict how many sessions you might need. After I know more about your situation and the issues that you want to resolve, I will be better able to discuss the number of sessions you might need.

## **THE THERAPY PROCESS**

In the first session, we will spend time exploring the difficulties that you are having. It is important to discuss your issues openly and honestly with me. Your specific goals for positive changes will be discussed. Sometimes we might need to add new goals and interventions in the following sessions so that you can experience more positive changes.

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