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CONSENT FOR TREATMENT

Thank you for selecting me for your counselor. The intent of this form is to inform you about the basic treatment relationship between counselor and client, to inform you of basic policies and to help ensure that you understand our professional relationship.

COUNSELING PHILOSOPHY, EXPECTATIONS OF CLIENTS:

I believe strongly in the capacity of people to help themselves and I see our counseling relationship as one in which you are in charge of setting your own goals and I am privileged to travel with you as you work toward attaining your goals. I expect that you will be involved in the counseling process and that you understand that I will work with you, not for you. My approach to therapy is basically a holistic one: we will discuss your issues from many perspectives and examine the effects on your body, mind, work, spirit, relationships and any other areas that may be meaningful to you. Your decision to choose to enter counseling is a voluntary one and you may terminate it at any time without penalty. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will do so because ethical standards dictate this course of action. I will provide you with names and numbers of therapists for you to contact, if you wish. Whether you choose to continue counseling with another therapist is entirely your decision. Please note that it is impossible to guarantee any specific results for you. Sessions are 45 - 50 minutes in length unless specified in advance. By signing this consent, you agree to be in a counseling relationship. A copy of this informed consent will be provided, and I will be considered your therapist. The relationship will be in effect until termination occurs or until I have not seen you in session for more than four weeks from the date of our last scheduled session unless you and I have a prior agreement to leave your case open for a specified amount of time. (See Termination, page 2)

SCOPE OF PRACTICE, EMERGENCY CONTACT:

I operate an outpatient private practice, working with children, adolescent and adults. I offer individual, family, couples and group therapy. I do not have an emergency practice. Clients are assumed to be self-responsible, autonomous, functioning individuals who are not in need of day to day supervision. I cannot and do not assume responsibility for client's daily functioning the way that institutions can. I return routine client calls received during office hours within 24 hours. If it is a Friday or weekend your 24 hour period begins on the following Monday. On occasion, there may be an unavoidable delay: I appreciate your understanding in this circumstance. When I am out of office for an extended period of time I will leave detailed information on my voicemail about when I will be returning phone calls. My fax line, (770) 993-8004, is not available for leaving messages. You always use the main line, (770) 592-0566.

IN THE EVENT OF AN EMERGENCY:

You can receive 24 hour assistance from Ridgeview Institute by calling (770) 434-4567. Should you experience a life or death emergency immediately call 911 or go to your nearest hospital emergency room.

CONTACTING YOU:

When I contact you I will attempt to be discreet when identifying myself. If there are special instructions about how to contact you and if a message cannot be left you must provide this information. Please note if you have caller ID, East Cobb Center for Therapy, Private Caller or my name may appear on your caller ID screen.

***Please initial that you have read and understood this page_____**

TEXTING AND EMAIL POLICY:

E-mail and texting (hereafter called electronic communication) cannot be assured to remain private due to the nature of most electronic communication programs (not encrypted). My electronic communication programs are not encrypted, thus electronic communication is not completely secure or confidential. Therefore, only administrative concerns will be addressed via electronic communication – no therapeutic issues will be discussed. If you choose to send me an electronic communication, engage in electronic communication with me or request that I send a statement via electronic communication, please be aware that all electronic communications are retained in the logs of your and my internet and phone service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the electronic service provider. You should also know that any electronic communication that I receive from you may be printed and kept in your treatment record.

SOCIAL MEDIA POLICY:

I do not accept friend requests from current or former clients on my personal Facebook page, or on Linkedln. My belief is that adding clients as "friends" or "connections" can compromise confidentiality and confuse the boundaries of our relationship. If you have questions about this, please feel free to bring it up in session and we can briefly talk about it.

APPOINTMENTS:

I will make every effort to begin and end sessions on time. Your next appointment will be scheduled at the end of each session. Please be mindful of the length of your session as I generally have consecutive appointments and want to be respectful of the next person's time. If you cannot keep your appointment time, you must give me at least a FULL 24 hours notice to avoid payment of your scheduled session. If you miss a scheduled appointment without notifying me, you will be charged $125 per scheduled hour. If you are going to be more than 15 minutes late for your appointment, please let me know by calling (770) 592-0566 and leaving a message on my voice mail. Otherwise, if you are more than 15 minutes late, I will assume you are not coming to the appointment and may not be available. In this situation you will be responsible for the missed appointment and required to pay the session fee of $125. Session fees and lengths are not prorated if you are late.

INSURANCE:

It is your sole responsibility, as the client, to obtain any authorization needed from the insurance company. If you are seeing a psychiatrist in conjunction with me it will be important to periodically keep track of the number of sessions you have available throughout our relationship, as many insurance companies expect the therapist and the psychiatrist to "share" appointments authorized. This often leads to confusion as to the number of actual sessions you have available for therapy with me. If the insurance company denies any service it will be your responsibility to pay for the service and attempt to collect from the insurance company.

Due to the amount of administrative time and cost involved in attempting to collect payments from your insurance company, a $30 administrative fee will be assessed to your account for each attempt to collect for dates of service 30 days following my filing the claim. I will do my best to limit the number of attempts by combining dates of service, when possible, for each call. I file your insurance claim as a courtesy to you. If I am unsuccessful in collecting payment from your insurance company, you will be responsible for payment for the contracted insurance rate. I will be happy to provide you with a copy of the original claim submitted on your behalf so you may attempt to seek reimbursement.

TERMINATION:

Your decision to enter counseling is a voluntary one and you may terminate counseling at any time you wish without penalty. Termination of the counseling relationship is also a natural occurrence when your goals for counseling have been met. The counseling relationship may also if, in my professional opinion, it is in your best interest for me to refer you to another therapist, as ethical standards dictate this course of action (See Counseling Philosophy, page 1). Termination will occur automatically if I have not seen you in a counseling session for 4 weeks from our last scheduled session, unless you and I have a prior agreement to leave your case open for a specified amount of time. Should you re-enter counseling with me after your case has been closed, you may be required to complete this paperwork process again and any new changes will apply when you re-enter treatment.

***Please initial that you have read and understood this page_____**

CONSULTATION:

In keeping with accepted standards of practice and to ensure quality of care, I regularly consult with other mental health professionals regarding clients. Client identity is protected at all times.

RECORDS:

Your file is kept for at least 7 years from the last date seen. For minors, this 7 year period begins when you turn 18 years old. Your file contains my copy of this informed consent, your client information form and all materials that pertain to you including notes that I take. This file is confidential with the exceptions noted in the following section titled "Confidentiality and Exceptions". Your file is protected by 2 locks and will be destroyed by shredding at the end of the 7 year period.

CONFIDENTIALITY AND EXCEPTIONS:

Please keep in mind that I will keep confidential anything you tell me, with the following exceptions, as mandated by the law:

1. You direct/allow me to tell someone else by signing a release of information.
2. I determine you are a danger to yourself or others.
3. I am ordered by a court to disclose information.
4. You abuse a child or elderly person.
5. If you are under 18 years old and you report you are a victim of physical or sexual abuse.

**Children and adolescents have additional limits to confidentiality which will be addressed in the initial assessment. These limitations pertain but are not inclusive of alcohol and drug use, running away, truancy, sex and other safety issues.

DIVORCE, CUSTODY OR COURT RELATED WORK:

If I am seeing a child whose parents are in the process of divorce or who are already divorced, I may require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

I ask all my clients waive right to subpoena me to court. This policy is set in order to preserve the efficacy and integrity of my therapeutic process and relationship with you and/or your child(ren). It is my experience that my appearance in court often damages the therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving the right to have me subpoenaed and are agreeing to the fact not to have my records subpoenaed.

In the case that I am subpoenaed to appear in court even with this waiver, whether I testify or not, I charge my standard fee for court related work of $250.00 per hour of my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court case will be billed at this rate.

Should I need to appear in court, travel time, time waiting at the court house or on the stand will be billed at the rate of $250.00 per hour with a 4 hour minimum. Court appearances are set in 4 hr increments and payment for the first 4 hours is required prior to my appearance in court.

Any counseling that has been court ordered or suggested by any legal entity will be paid at my rate of $125.00 per session. You are responsible for full payment at the time of services rendered. If you wish, you may seek reimbursement from your insurance company.

***Please initial that you have read and understood this page_____**

ETHICAL GUIDELINES AND STANDARDS:

I assure you that my services will be rendered in a professional manner consistent with the ethical standards for licensed clinical social workers. If at any time you are dissatisfied with my services, please let me know. I am open to discussing any concerns you may have regarding our work together. If we are not able to resolve your concerns, you may report your complaints to the Georgia Composite Board for Licensed Counselors, Social Workers and Marriage and Family Therapists. For a copy of the code of ethics to which I adhere, you may contact the above board.

HIPPA AND PRIVACY PRACTICES:

Please review the Notice of Privacy Practices provided to you as part of this new client information. It describes in more detail your rights with regard to Protected Health Information. By signing this Consent for Treatment, you are acknowledging your receipt of the Notice of Privacy Practices.

FEES:

Individual, family and couples therapy is charged at a rate of $125.00 per session on average. Group therapy is charged at a rate of $45.00 per session.

PHONE CALLS:

Longer than 10 minutes: $1.00 per minute after the first 10 minutes (first 10 minutes are N/C).

TIME RE: YOU (NON SESSION TIME):

$1.00 per minute (Example: Consultations with others at your request).

PAPERWORK TIME:

$125.00 PER HOUR (Example: Writing reports related to you at your request).

BILL PREPARATION:

$10.00 (Example: An itemized bill for you to give to your insurance company. This is not billable to your insurance company).

CHARGES:

Please be aware that I charge for and expect payment for phone time (time after 10 minutes) for non-session time related to you. Payment is due at your next session following the rendering of services. At your request, a superbill for these services will be provided at no charge.

Should it become necessary to raise my therapy fee, you will be given 2 months' notice.

PAYMENT:

PAYMENT (CHECK, CASH OR CREDIT CARD) IS DUE AT EACH SESSION. Please have your check made out before you arrive. Credit card transactions are for $100.00 minimum. You may pay several co-payments in advance to reach the credit card minimum. There is a $3.50 surcharge for each credit card transaction. Please note; the fee for a check returned for Insufficient Funds is $30.00. Mastercard and Visa accepted.

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MY PERSONAL STATEMENT AND PHILOSOPHY ABOUT BEING A THERAPIST:

I believe it is crucial for me, as a therapist, to take very good care of myself personally, emotionally, psychologically, educationally and spiritually. I do this in a number of ways. I believe it is important to balance work, personal and family time and I do my best to practice what I preach by taking care of myself in ways that reflect this belief. All of this means that there will be times when I will not be available. Occasionally, I may be unavailable for an extended length of time. I will inform you of my planned absence in advance. Should you need support during this time, I will provide you with a name and number of another therapist you can contact if you feel the need to do so.

Your signature indicates that you agree to adhere to the policies specified in this document.

_____ _____

Client's Signature Date

***Please initial that you have read and understood this page_____**