CONSENT FOR TREATMENT

Thank you for selecting me as 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 50 minutes in length unless specified in advanced. 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. This relationship will be in effect until termination occurs or until I have not seen you in session for more than 4 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 3)

SCOPE OF PRACTICE, EMERGENCY CONTACT:

I operate an outpatient private practice, working with children, adolescents 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 clients' daily functioning the way that institutions can. I return routine clients calls received during office hours within 48 hours. If it is a Friday afternoon or weekend your 48 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 the office for an extended period of time I will leave detailed information on my voicemail about when I will be returning phone calls. Our fax line (770) 517-3308, is not available for leaving messages. You always use the main line (770) 517-3363.

IN THE EVENT OF AN EMERGENY:

You can receive 24 hour assistance at Ridgeview Institute by calling (770) 431-7077. Should you experience a life or death emergency, you should 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 can not be left you must provide this information. Please note if you have caller ID, Towne Lake Counseling or my name may appear on your caller ID screen.

***Please initial that you have read and understood this page _____**

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 respectful of the next person's time. If you cannot keep your appointment time, you must give me a 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 $100 per scheduled hour. If you are going to be more than 15 minutes late for your appointment, please let me know by calling (770) 517-3363 and leaving a message on my office voice mail. Otherwise, if you are more than 15 minutes late, I will assume you are not coming to the appointment and may be unavailable. In this situation you will be responsible for the missed appointment and required to pay the session fee of $100. Session fees and lengths are not prorated if you are late.

INSURANCE:

It is your sole responsibility, as the client, to obtain any authorizations needed from an 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 reimbursement from the insurance company.

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 be terminated 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 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. 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.

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 a least 7 years from the first 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 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 destroyed by shredding at the end of 7 years.

*Please initial that you have read and understood this page _____

CONFIDENTIALITY AND EXCEPTIONS:

Please understand that I will keep confidential anything you tell me, with the following exception, 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 to others.
3. I am ordered by a court to disclose information;
4. You abuse a child or an 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 confidentially which will be addressed in the initial assessment. These limits pertain to but are not inclusive of alcohol and drug use, running away, truancy, sex and other safety issues.

ETHICAL GUIDELINES AND STANDARDS:

I assure you that my services will be rendered in a professional manner consistent with accepted 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.

FEES: Individual, family, and couple's therapy is charged at a rate of $125.00 per session (on average). Group therapy is charged at a rate of $40.00 per session.

PHONE CALLS: Longer than 10 minutes: $1.00 a minute after first 10 minutes (first 10 minutes are n/c)

TIME RE: YOU (NON-SESSION TIME): $1.00 a minute (Ex.: consultations with others at your request)

PAPERWORK TIME: $100.00 an hour (Ex.: writing reports related to you at your request)

BILL PREPARATION: $10.00 (Ex.: 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 these 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 minimum. You may pay several co-payments in advanced to reach this minimum. Please note, the fee for a check returned for Insufficient Funds is $30.00.

***Please initial that you have read and understood this page _____**

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 physically, 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 2-3 weeks at time. I will inform you of my planned absence in advance. Should you need support during this time, I will provide you with the 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 _____