Solutions Therapeutic Services

109 Central Ave.
Cartersville, GA 30120
(770) 383-8909
(770)383-8930-fax

INFORMED CONSENT AND AUTHORIZATION

PLEASE READ THE FOLLOWING REGARDING MY TREATMENT POLICIES AND SIGN BELOW:

1. **Confidentiality:** All communication between counselor and client is held in strictest confidence unless:
   A. The client authorizes release of information with a signature and waives this privilege.
   B. The counselor is ordered by a court to release information.
   C. Dependent abuse/neglect is suspected or revealed.
   D. The client appears to pose a direct threat to his/her or someone else's life (ex. actively suicidal or homicidal).
   E. Patriot Act

   Note: You will receive a card from your therapist with all of the possible ways for contacting them. Please note that it may take your therapist 24-48 hours to return your call.

2. **Regarding children:** Children (under the age of 18) are only seen with signed permission from a parent/caregiver who has legal custody of the child. Parents have a right to any and all confidential information regarding your dependent. Because the presence of trust is important in the therapeutic relationship between your dependent and us, it is generally best that we do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your dependent's treatment plan, and the progress being made toward treatment goals. If your dependent is able to understand the issue of confidentiality, we will discuss with him/her the type of information that will be shared with you. If you have objections to this manner in which information is shared with you regarding your dependent, we will need to resolve these differences before therapy begins.

3. **Court testimony:** We are not trained in matters that involve the legal system. If required to testify for court, speak with legal counsel, etc. our fee is $180.00 an hour plus mileage and expenses incurred. We will not testify in divorce custody or mediation**. A two hour minimum is charged.**

4. **Case consultation:** I occasionally consult with colleagues regarding cases in order to provide clients with the best possible care; in these situations I normally do not disclose client names or other identifying information.

5. **Digital Policy-** Individuals may contact their respective therapist using technological resources. In doing so, they agree to the understanding that cell phone, text, email and fax communication are not guaranteed confidential methods of communication. When used, the client is, by choice, relinquishing their rights to confidentiality. Please be mindful that should you send an email to your therapist, we will review your email at the beginning of the next session.
   Texting is allowed for scheduling or rescheduling appointments; no clinical dialogue will be shared via text.

6. **Therapy Treatment:** We expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. We will try to make our professional relationship one where you will receive the maximum benefit. We will also keep you informed about alternatives to therapy. Therapy may be tremendously beneficial for some individuals. At the same time, there are no guarantees for therapeutic treatment and there are some risks. These risks may include recalling unpleasant events, facing unpleasant thoughts or beliefs, increased awareness of feelings and/or alteration of your ability or desire to deal effectively with others in a relationship. In therapy, major life decisions are sometimes made. As your therapist, we will be available to discuss any of your assumptions, problems or possible negative side effects of our work together.

7. **Couples Therapy:** The couple is the client in which both partners attend each therapy session. The therapy goal is to ask you to be committed to the process of couples therapy, not the outcome. In marital and family therapy, no secrets will be kept among those actively participating in the therapy. If one partner does not attend a session, this will be seen as a late cancellation and a fee will be charged. If one partner wishes to continue therapy and the other does not, a couples session should be conducted to address future treatment. Records will only be released if <u>both</u> parties sign consent.

8. **Termination of therapy:** Termination of therapy may occur at any time and may be initiated by you as the client or by the therapist. In either event, a final termination session is strongly recommended to explore the termination process itself. This can provide a constructive and useful conclusion to treatment. Referrals or other suggestions will be offered at that time.

9. **Solutions Therapeutic Services** is the name for a group of individual therapists who have their own practices in this facility. Each therapist is licensed to practice in the state of Georgia. Each therapist abides by a Code of Ethics specific to their specialization. Please be aware that each therapist is solely responsible, both ethically and legally, for all aspects of your therapeutic care. Likewise, you must address any billing problems and/or complaints to your therapist alone. No practitioner at Solutions Therapeutic Services, other than your own therapist, is legally or ethically responsible for any aspect of your care or treatment, services or billing. I encourage you to raise any concern you may have about the facility, your treatment and billing, or any other issues relevant to the services provided here, with your therapist as soon as you become aware of it.

Fees and Charges Consent Form

1. Fees, Charges, and Responsibility for Payment: Sessions are 45-60 minutes in length. My fee is $100.00 an hour; please pay in full by cash or check after each session, unless arrangements have been made with your insurance company. It is the client's responsibility to obtain any necessary Authorizations for use of insurance. If your insurance should change within treatment, it is the client's responsibility to inform their therapist and obtain necessary authorizations, failure to do will result in client paying any balance due.

Any insurance co-pays are due at the time of service. As the insured, I am responsible for paying any co-pays dues on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner as well as any deductibles that have to be met. If you are using insurance, please note that a diagnosis will have to be provided to your insurance provider in order to submit the claim for payment.

All credit cards are accepted, as well as Heathcare Spending Account debit cards.

A fee of $25 plus additional expenses incurred will be applied should your check be returned. You will also be responsible for any expenses incurred to collect unresolved balances as well as 25% additional fee.

2. Contact Procedures: Sessions are scheduled directly with your therapist. You are required to give at least a 24 hour notice to your therapist in advance if you are unable to keep a scheduled appointment to prevent being billed for the session. You can reach your therapist at 770-383-8909 and leave a voicemail on their specific voicemail.

You will be responsible for payment ($50) if less than 24 hours notice is given. Insurance does not cover missed sessions.

3. Forms, Letters and affidavits will incur a $25 per report fee.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK YOUR INDIVIDUAL THERAPIST.

By signing below, I attest that I understand that my therapist will do all that is necessary to file insurance benefits on my behalf and I authorize the release of any PHI as necessary to complete the insurance billing process.

I have read and understand the conditions as stated above. By signing below, I authorize my therapist to begin therapeutic treatment at this time.

Please provide a person to contact in case of emergency and a contact number here:

Emergency Contact:_____Phone #:_____

Client Signature:_____Date:_____

Therapist Signature:_____Date:_____