Solutions Therapeutic Services

109 Central Avenue

Cartersville, GA 30120

(770) 383-8909 – (770) 383-8930 fax

www.solutionstherapeuticservices.com

INFORMED CONSENT, AUTHRORIZATION, TELEMENTAL HEALTH, AND TREATMENT

Thank you for choosing the services we provide. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and other details regarding your treatment. We will reach for maximum benefits during our professional relationship and expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. Therapy can be tremendously beneficial for most individuals and for some, risks may apply. There are no guarantees for therapeutic treatment and some of these risks may include recalling unpleasant events, thoughts, or beliefs, an increased awareness of feelings and/or alteration of your ability or desire to deal effectively with others. As your therapist, we will be available to discuss any of the assumptions, problems, or possible negative side effects of our work together as we process through life. We have developed several policies and protective measures to assure your Personal Health Information (PHI) remains confidential.

Fees: Payment can be made by cash, check, credit/debit card, or healthcare spending account debit cards. Fee per session is $125.00 an hour for all methods of service. Sessions are 45-60 minutes in length. Any insurance co-pays are due at the time of service. You are responsible for any denied claims that were properly filed in a timely manner, as well as any deductibles that must 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. A 24-hour notice of cancellation is required if you are unable to keep a scheduled appointment. You will be responsible for a $50 payment if less than 24-hour notice is given. Attempt to reach your therapist directly or leave a voice at the office 770-383-8909. A fee of $25 plus additional expenses incurred will be applied to returned checks. Forms, letters, and speaking with legal counsel, and affidavits will incur a $25 report fee. Matters that involve the legal system, such as a requirement to testify for court is a fee of $180.00 an hour plus mileage and expenses incurred and will be billed prior to attending with a two-hour minimum. We will not testify in divorce, custody, or mediation.

Different Forms of Treatment

At Solutions Therapeutic Services we offer primarily face-to-face counseling at our office location. Based on your ability to make in-person sessions, your therapist may provide phone or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If TeleMental Health will be primary utilized for service, we require one face-to-face meeting at the onset of treatment at our office. If that is not possible, please speak to your therapist to make other arrangements. If phone, text, or video conferencing is used, you will choose a password, phrase, or number which you will use to identify yourself in all future sessions. You and your therapist will discuss what is best for you.

Cell phones and landlines: Cell phones and landlines may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept conversations with special technology. If you provided us with a landline or cell phone number, we may contact you on this line for the purposed of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your therapist know. We realize that most people utilize cell phones, we may use a cell phone to contact you and your therapist may keep your phone number in his/her cell phone by your initials only and his/her cell phone is password protected. Please let your therapist know if this is a problem and they will be glad to discuss other options. Phone conversations, other than just setting up appointment, are billed at your therapist hourly rate.

Text Messaging and Email: Text messaging and email is not a secure means of communication and may compromise your confidentiality. We realize that many people prefer to text or email, it is a quick way to convey

information. Nonetheless, please know that it is our policy to utilize this means of communications strictly for appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. Note that we are required to keep a copy of summary of all texts and email as part of your clinical record that address anything related to therapy.

Video Conferencing: Video conferencing is an option for your therapist to conduct remote session with you over the internet where you speak to one another and see each other on a screen. We utilize Doxy.Me.com. This platform is encrypted to the federal standard, HIPPA compatible, and has signed a HPIAA Business Associate Agreement (BAA). The BAA means that Doxy.Me.com is willing to attest to HIPAA compliance and assumes responsibility for keeping your video conferencing interaction secure and confidential. If this technology is utilized, you therapist will give you detailed directions regarding how to log in securely. We ask that you please sign onto the platform at least five minutes prior to your session for a prompt start.

Social Media – Facebook, Twitter, LinkedIn Instagram, Etc.: It is our policy not to accept "friend" or "connection" requests from any current or former client on any of our therapist's personal social media sites. It may compromise your confidentiality and blur the boundaries of the relationship. If you are comfortable with the general public being aware your name is attached to Solutions Therapeutic Services, we have a professional Facebook page and you are welcome to "Follow" us.

Recommendations to Websites or Applications (Apps): During treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. They may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow software and other entities to know that you have visited these site or apps. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment.

We strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protect, not assessing the internet through a public wireless network, etc.). It is your responsibility to choose a secure location to interact with technology and to be aware that others could overhear your communications or have access to your device. Additionally, you agree not to record any TeleMental health sessions. If you are in a crisis, please do not communicate this to us via text or email, we may not see it in a timely matter. Instead, please see below under "Emergency Procedures".

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 with the exception of raw test data. 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 towards 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.

Confidentiality: All communication between counselor and client is held in strictest confidence unless: client authorizes release of information with a signature and waives this privilege, counselor is ordered by a court to release information, child/elder abuse/neglect is suspected or revealed, client appears to pose a direct threat to themselves or someone else's life, and the Patriot Act. In addition, your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with Solutions Therapeutic Service secure storage company who has signed a HIPAA Business Associate Agreement (BAA). Likewise, if your therapist is credentialed with your insurance carrier, we utilized billing service who has access to your PHI. Your PHI will be securely transferred electronically to Navicure. This billing company has signed a HIPPAA (BAA). The BAA ensure that both companies will maintain the confidentiality of your PHI in a HIPPAA compatible secure format using point-to-point, federally approved encryptions. An electronic transfer of PHI for credit card transactions through the company Square, will processes your credit card information. Solutions Therapeutic Services will appear on your credit card bill. Receipt of these

transactions can be through text message or email, in order to maintain your confidentiality please let us know if and how you would like to receive a receipt. Occasionally case consultation with colleagues will take place regarding cases in order to provide clients with the best possible care, name or other identifying information is not disclosed.

Termination of therapy may occur at any time and may be initiated by you as the client or by the therapist. In either evet, a final termination session is strongly recommended to explore the termination process itself. This can provide a constructive and useful conclusion to treatment.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from your therapist, but do one or more of the following: Call Behavioral Health Link/GCAL: (800)-715-4225, Call Lifeline at (800) 273-8255 (National Crisis Line) or Call 911

Mental Health Emergency

Understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely or face to face, we may determine that you need a higher level of care.

You agree to inform you therapist of the address where you are at the beginning of every TeleMental Health Session.

We require an Emergency Contact Person (ECP) to contact in an emergency or if we do not hear from you regarding scheduled appointments. Your ECP needs to be willing and able to go to your location and if necessary, take you to the nearest hospital of your choice.

Emergency Contact Person: _____Phone: _____

Hospital:_____Phone:_____

Solutions Therapeutic Services is the name for a group of individual therapists who have their own practices in the facility. Each therapist is licensed to practice in the State of Georgia, or under supervision for a licensed professional. The 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. 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.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK YOUR INDIVIDUAL THERAPIST. By signing below, I attest that I understand my therapist will do all that is necessary to file insurance benefits on my behalf and I authorize the release of any Private/Personal Health information as necessary to complete the insurance billing process. I have read and understand the conditions as stated above and by signing below I authorize my therapist to begin therapeutic treatment at this time.

Client Signature: _____ Date: _____

Print Client Name: _____

If Applicable: Parent's or Legal Guardian's Name: _____

Print Parent's or Legal Guardian's Name: _____Date: _____

Therapist Signature: _____Date: _____