Therapy Agreement, Policies & Consent

PART 1: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse** - Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. (Georgia Code 19-7-5). If you reveal information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse** - Vulnerable adult abuse or neglect (Georgia Code 19-7-5). If you reveal information vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself – I am permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information. (Georgia Code 19-7-5).
- **Harm to Others**: Threats regarding harm to another person (Georgia Code 19-7-5). If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for you records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you written correspondence (if I can not get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy**: If you are in therapy ordered by the court, and the court requests records or documentation of your participation in services, I will discuss the information/documentation that will be discussed/sent on your behalf prior to sending information to the court.
- **Written Request**: Your specific written request, in writing is required, to disclose information regarding your psychotherapy to you or to a third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("psychotherapy/process notes"), I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records. If therapy sessions involve more than 1 party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation i.e. your signature on the "Therapy Agreements and Consent" that covers the cancellation policy to your bank or credit card company should you dispute a charge for which you are financially responsible. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the goal of therapy for the couple. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public**: My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.
- **Social Media**: I do not accept requests to connect with current or former clients on my personal social media accounts. If you choose to connect with me on any of my professional social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, you do so at your own risk. If you choose to comment on my pages or posts, you do so at your own risk and may breach your own confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and

should not replace therapy. Please do not contact me through any social media site or platform as these platforms are not confidential, nor are they monitored, and may become part of your medical record.

- **Electronic Communication: My preference for communicating is through phone contact.** Clients will often use text or email as a convenient way to communicate, which can introduce unique challenges into the therapist–client relationship. Below are some guidelines for to consider. **Do not use text or e-mail for emergencies**. If it's an emergency, call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for seeing me. If you think that you might need to be seen, please call to book an appointment. E-mails should not be used to communicate sensitive medical or mental health information. **E-mail is not confidential**. Be aware that if you send e-mails from your work, your employer has the legal right to read your e-mail. E-mail is a part of your medical record. Texting introduces some of the same challenges. Like e-mail, it is not a substitute for seeing me or making an appointment. **Texting is not confidential**. Phone calls can be intercepted or lost or stolen. It is imperative that you do not communicate information of a sensitive nature over a text. Further, I cannot know the person who is texting is actually you, because someone else could be in possession of your phone.
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location i.e. their home, in public, at work, or somewhere more conducive for them. We are more than happy to accommodate your request, but please know that you may be taking a risk in regards to your confidentiality. I cannot fully protect your confidentiality if we meet in a location other than my office.

PART II: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving initial concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to provide you with the most effective therapeutic services. I make no guarantees as to the ultimate outcome of therapy.

EXPECTATIONS: Work outside of the counseling sessions is an essential aspect of change. I may assign tasks between sessions related to your goals. My commitment is to work as efficiently as possible and at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals, periodically review your progress toward them, and modify our treatment plan as needed.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be taken to achieve the results you desire. Sometimes in taking these actions you may experience discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work together for a desirable outcome; however, there is a possibility that the goals of therapy will not be met.

STRUCTURE OF THERAPY:

- **Intake Phase** – During this phase, we will discuss the process, structure, policies and procedures of therapy. This occurs during the 1st session. We will explore your experiences surrounding the presenting complaint(s) or problem(s).
- **Assessment Phase** – An initial evaluation may last from 2-4 sessions. During the assessment phase, I am getting to know and understand you, your worldview, strengths, concerns, needs, relationship dynamics, etc. During this phase, I am gathering a lot of information. It may not feel like we are moving forward quickly, but it is imperative for me to gather this information to assist you the best I can. During this time, if we both

decide I am not the best person to provide therapeutic services for your specific needs, I will refer you to an appropriate treatment provider.

- **Goal Development/Treatment Planning** – After we have explored and developed sufficient background to proceed, we will collaboratively identify specific therapeutic goals. If you are court ordered, goals will encompass both what is important to you and what the court is requiring for your treatment. If you are court ordered, please provide copies of documents from the court stating what needs to be addressed during our counseling sessions. After the goal is completed, we will both sign the goal and you will receive a copy.
- **Intervention Phase** – This occurs anywhere from session 2 until graduation/discharge/termination. This phase requires effort both in session and completing any agreed upon assignments outside of session. You will maximize therapy by implementing solutions discussed during session. During this phase, we will review your progress and make adjustments to your goals as needed. If you have questions about my approach or where we are headed, please do not hesitate to ask.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing your goals, we will collectively discuss your progress, make a transition plan and decide on the date of graduation/discharge/termination.
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LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 45 minutes depending upon the nature of the presenting challenges and what your insurance authorizes. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine from session to session and based off your insurance how much longer therapy is recommended.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you agreed upon. You agree to adhere to the following policy: ***If you are prevented from keeping a scheduled appointment, you MUST notify me 48 hours in advance to cancel or reschedule your appointment. If you cancel or reschedule more than once in a 48-hour time period, we will discuss your need, desire and motivation for treatment at this time.***

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I will periodically take time off for vacation, seminars, and/or become ill. I will attempt to give you adequate notice. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague contact you to cancel or reschedule an appointment.

FEES: My fee for each 45-minute session is $150.00 or a discounted fee if worked out in advance. Payment is due at the time of the session in the form of exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $35.00 for any returned check), or credit/debit card. If you miss your scheduled appointment time or cancel less than 48 hours, please refer to the "Appointments and Cancellations" policy above.

I reserve the right to terminate our counseling relationship if more than 2 sessions are missed without proper notification.

I charge my hourly rate in quarter hours for any communication such as phone, text, email or postal mail correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed to your credit card or required of you via check or cash.

In-home/On-site therapy services offer people comfort and flexibility. In-home/ On-site services are offered at a regular hourly rate. Cost for travel is based on the regular hourly rate and is determined by the time it takes for the me to travel from the office to your home or requested place of session and back. Time is configured by tracking and logging actual time or internet sites such as Google, Bing, Mapquest, etc. to determine travel time.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in court. If I get called into court by you or your attorney, you will be charged a fee which is $400.00/hour and will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc.

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404.293.5654
P.O. Box 663
Holly Springs Georgia 30142

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, they will be dispensed at $2 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at our office. Please allow at least 2 weeks to prepare your records.

PHONE CONTACTS AND EMERGENCIES: Office days and hours vary at the various offices to which I travel. If you need to contact me for any reason please call 404.293.5654, leave a voicemail, and I will get back to you within 24 hours, or as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911. For mental health evaluations, you may also call Ridgeview Institute (844) 350-8800, or Peachford Hospital (770) 455-3200.

PART III: HEALTH INSURANCE

YOUR INSURANCE COMPANY – By using insurance, I am required to give you a mental health disorder diagnosis that goes on your medical record. I am not required to tell you the diagnosis, but as best practice, it is my policy that we collaborate on this information. You may have had a previous diagnosis from another treatment provider. After my assessment, if I clinically determine that you have the same diagnosis, I will use that diagnosis. If I assess you and clinically determine otherwise, I will discuss that information with you before providing you with either a new diagnosis or secondary diagnosis. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding your treatment.

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy. In the event of non-coverage or denial of payment, you will be responsible to pay for such services. Advent Counseling and Training Services Inc. reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to you.

PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY– When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, your therapist may need to justify the need for continued service potentially causing a delay in treatment. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you do not feel you have achieved your therapeutic goals. Your insurance company may request or require additional clinical, confidential information in order to approve or justify a continuation of services. I cannot assure or guarantee your confidentiality when an insurance company requires this information to authorize continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services regardless if you think you need continued therapy or not. For these and other reasons, many therapists discuss "the myth of confidentiality" whenever insurance companies become part of the therapeutic process.

POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS– Insurance companies require the therapist to give you a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") in order to get reimbursed. Psychiatric diagnoses may come back to negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations that require revealing that you have a mental health disorder diagnosis. This includes but is not limited to applying for job applications, applying for financial aid, and concealed weapons permits.
5. A psychiatric diagnosis can be brought in a court case such as a family law, criminal, etc.

It is important for you to be an informed consumer, so you can empower yourself in regards to your health and medical record. At times, having a diagnosis can be helpful such as in the case of a child needing extra services in the school system or a person being able to receive disability.

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EMERGENCY CONTACT:

It is necessary that **Advent Counseling and Training Services Inc.** has someone to contact on your behalf. In case of an emergency, who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank you.

☐ I agree to allow **Advent Counseling and Training Services Inc.** to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Advent Counseling and Training Services Inc. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Advent Counseling and Training Services Inc. to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to Advent Counseling and Training Services Inc. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, Advent Counseling and Training Services Inc. may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to** Advent Counseling and Training Services Inc. **to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Advent Counseling and Training Services Inc. prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Minor Child	DOB	Date

* *Your signature signifies that you have printed or electronically kept a copy of the* "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name	Signature	Date

_____

Witness – ***James Ciraky PhD, LPC*** *Date*

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CLIENT COPY

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