Informed Consent for Counseling Services

Client Name: _____ Date: _____

THERAPIST-CLIENT INFORMED CONSENT AND SERVICE AGREEMENT

Welcome! My name is Michael William Tanner, M.S., LMFT. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future. There is a summary document for you to take home with reminders of what we discuss today.

THERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

RISKS AND BENEFITS

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

ASSESSMENT

The first 1-2 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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APPOINTMENTS

Appointments will ordinarily be 30-60 minutes in duration, 1-4 per month at a time and location that we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. The primary address for all sessions shall be 2011 Commerce Dr. N, Peachtree City GA, 30269

CANCELLATIONS AND LATE FEES

If you need to cancel or reschedule a session, I ask that you provide me with as much notice as possible.

Sessions that cancelled within 24 hours of session time shall incur a $25 late cancellation fee (after the first occurrence). Sessions that are missed entirely shall incur a $50 no show fee (after the first occurrence). A $50 no show fee shall also be applied to clients whom are more than 15 minutes late to their scheduled appointment. Late cancellations and missed appointments share the same "one-time" grace period and shall be treated as such.

I will not continue to reschedule missed appointments. If you need to cancel, my phone number and email address provided on the handout that you have been provided. Furthermore, clients shall be provided with a virtual link to schedule their own appointments on clinician's calendar after their initial session.

All balances accrued from late charges and no-show fees must be settled prior to subsequent sessions being honored.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.
It is the policy of Wellspring Living that therapy and treatment records will not be released without a court order, given that these privileged communications between a patient and

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licensed therapist are protected by Georgia Law.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

Although I can receive your calls at any time, I appreciate your saving therapy issues for our sessions and reserve calling me for scheduling or emergency situations.

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. Please be aware that I cannot guarantee the security of my personal cell phone and take this into consideration when leaving your message.

If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. You can also call the Georgia Crisis and Access line at 1-800-715-4225. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my cases.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients. A scanned copy of this document is as good as the original.

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CONSENT TO PSYCHOTHERAPY

I am requesting services provided by Michael Tanner M.S., LMFT and I give my consent for evaluation, treatment, and admission into the program of this facility.
Your signature below indicates that you have reviewed and received the Notice of Privacy Practices, and have read this Agreement and agree to their terms.

_____

Signature of Patient or Parent/Guardian

_____

Printed Name of Patient

_____

Phone Number

_____

Email Address

Date _____

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