CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES; CONFIDENTIALITY STATEMENT; & PAYMENT AGREEMENT

Consent to Receive Services

For adult clients:

I,_____, consent to receive psychotherapy, psychological testing, or other professional services from the above noted clinician at Mind Your Mind Counseling & Consulting.

For adolescent clients:

I, (parent's or guardian's name)_____, consent for my child (child's name)

_____to receive psychotherapy, psychological testing, and/or other professional services from the above noted clinician at Mind Your Mind Counseling & Consulting.

Confidentiality & Records: I understand that communications with me (or my child) will become part of a clinical record of treatment, referred to as Protected Health Information (PHI). My PHI will be kept secure in the office per HIPAA procedures. I understand that all information disclosed by me (or my child) in therapy or during a psychological evaluation is maintained in strict confidence. I understand that no information pertaining to my (or my child's) therapy or evaluation will be released to others parties without my consent, with the exception of the following: (1) I allow my clinician (or my child's clinician) to release information and I have signed a "Release of Information" form; (2) My clinician determines that I (or my child) am a danger to myself or to others; (3) My clinician receives information that suggests that a child, an elderly person, or a disabled individual has been abused or is at substantial risk of being abused and may require protection; or (4) My clinician is ordered by a judge to disclose information about me.

I am authorizing necessary disclosures to be made to my (or my child's) insurance company related to billing for any services furnished to me. I understand that I am authorizing the release of any information contained in my (or my child's) medical record to any relevant third party, or to its assignees, as requested by such third parties as necessary to pay any particular claim.

Any information about me or my child that is stored electronically in any means will be encrypted and otherwise stored and maintained in compliance with HIPPA requirements.

In the event of the clinician's death or disability, your clinical record will be maintained by Mind Your Mind Counseling & Consulting. If records are requested, or desired, and the office can legally and ethically provide those to you, the Practice Manager will make those records available.

Psychological Evaluations: I understand that if I (or my child) am receiving a psychological evaluation, the disposition of the report will be discussed with me and I will be asked to sign a release of information form if the report is to be released to any other individual or agency.

Initial the following when appropriate:

_____: I have read and understand the above, as discussed between the clinician and I

_____: I understand that the following individual or agency has been established as holding

"privilege" over my (or my child's) medical information→ _____

_____ : I give permission to release information in the future to anyone that the above-named holder of privilege allows the clinician to send information to.

I understand that by receiving an evaluation for any court or other legally or administrative related purpose, I am paying for the clinician's professional time involved, regardless of the clinician's ultimate diagnoses, findings, opinions or recommendations and the impact that those diagnoses, findings, opinions or recommendations have on my case.

Psychotherapy: I understand that information that I (or my child) provide to a clinical in therapy is legally termed "privileged communication," meaning that it is my (or my child's) right as a client to have a confidential relationship with a therapist. However, I understand that in very rare circumstances, a court may order the disclosure of my (or my child's) private information. I understand that if I am receiving couple's therapy or family therapy, my therapist does not agree to keep secrets, and any information revealed in any context may be discussed other family members.

Termination of treatment: If I (or my child) am an ongoing client, such as receiving therapy, I understand that if I miss a scheduled appointment, and I do not re-schedule within 60 days, my clinician will understand that as notice that I have voluntarily terminated services and the file will be closed. However, I can have the file re-opened and services resumed by calling the office and scheduling an appointment with my clinician.

Psychotherapy with children: If I am bringing my child for psychotherapy, I agree to allow my child to have some degree of privacy in his or her relationship with the therapist. It is my expectation that I will be made aware of my child's general progress in therapy, but I understand that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

Structure and Cost of Sessions: Cash, money orders, cashier checks and credit cards are acceptable for payment. We do not accept checks or insurance. A self-pay rate of $99 for each regular session and $125 for the initial intake will be billed and is due prior to the session. This office will provide, upon request, a receipt of payment. Unless alternative payment arrangements have been made prior to the delivery of services, payment is due at the time services are delivered.

By my signature below, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason. If I have insurance, with my signature below I am giving permission for appropriate charges to be billed to the insurance company. If I choose for my insurance not to be billed, I will discuss that with the provider. Unless other arrangements are made in advance with my clinician, such as payment by an insurance company or payment by any other third party, I understand the following fee structure and policies:

- **Psychotherapy:** The fee for the initial visit is $125. Subsequent visits are $99 per 45-50-minute session. Doing psychotherapy by telephone is not ideal, and I understand that needing to talk to my therapist between sessions may indicate that I need extra support, but I understand that any telephone calls that exceed 10 minutes in duration will be billed at $3.00 per minute.
- **Court and Deposition Testimony:** The fee for court or deposition testimony ranges between $275 and $300/hour, which includes all time required out of the office (i.e., including drive time) and/or time scheduled that the clinician otherwise would not be able to schedule or see clients. The fee for all preparatory time needed prior to the date of testimony is $200/hour, including for example all time needed in reviewing the file, preparation with the attorney, and/or needed communications related to preparation for testimony. I understand that if I request court testimony, I will be advised at that time of additional policies, such as retainer amount needed, minimum billable time that is applied to retainer, cancellations, or potential refunds.
- I understand that the fees noted above are subject to future increases.
- **Cancellation Policy** - I understand that if I do not show for an appointment, or if I cancel an appointment with less than 24 hours' notice, I will be financially responsible for that session. I understand that insurance companies do not reimburse for missed sessions. I further understand that repeated late cancellations or failure to show for scheduled appointments may result in my termination as a client. I understand that if I do not schedule or attend an appointment within 60 days of my last appointment, that will serve as notice to my clinician that I have voluntarily terminated as a client and the clinician will close the file, although my file could be re-opened in the future should I seek additional services.

In Case of an Emergency: Mind Your Mind Counseling & Consulting is an outpatient facility. The clinicians at this office do not carry pagers, nor are we available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 24-48 hours during the work week. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Ridgeview Institute at 770-434-4567
- Call Peachford Hospital at 770-454-2302
- Call the Georgia Crisis and Access Line at 1-800-715-4225
- Call 911
- Go to your nearest emergency room.

Professional Relationship: Psychotherapy are professional services that will be provided to you. Because of the nature of these services, your relationship with your clinician must remain professional, as there is the potential for harm if your clinician were to interact with you in other, non- professional ways.

Statement Regarding Ethics, Client Welfare & Safety: The services provided to you will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that we are not performing in an ethical or professional manner, please promptly this with your clinician immediately so we can work to resolve your concern.

Psychotherapy Considerations: Due to the very nature of psychotherapy, your therapist cannot guarantee specific results regarding your therapeutic goals. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life.

At times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success.

My signature below indicates that I have:

1) ***Read, been advised of, and understand the above information and that I give informed consent for me (or my child) to receive psychological services under these conditions,***
2) ***Read and I understand the HIPAA Georgia Notice form,***
3) ***Read and I understand the Social Media Policy form.***

_____

Client Name (Please Print)

For Adults:

_____ _____

Client's Signature **Date**

For Children:

_____

Parent's or Legal Guardian's Name (Please Print)

_____ _____

Parent's or Legal Guardian's Signature **Date**

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FOR OFFICE USE ONLY

_____ _____

Therapist Signature **Date**
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