Journey 4 Hope Counseling Center, LLC

Douglasville, GA 30134
404-500-9177

Client's Name: _____ Insurance: _____ DOB: _____

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to Journey 4 Hope Counseling Center. We are very pleased that you selected our agency for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at Journey 4 Hope Counseling Center. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Theoretical Views & Client Participation

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without the therapists here at Journey 4 Hope Counseling Center. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing, restoration and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

Consent for Treatment

I hereby give consent to receive mental health services from Journey 4 Hope counseling Center, LLC. I have been informed of the scope and purpose of the service and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

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Consent to Treatment of Minors

I hereby represent that I have the legal authority to obtain medical treatment and counseling for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent. If divorced and share authorization, I understand that both parents must provide written consent for minor child. I understand that I must provide legal documentation to verify guardianship and authority to consent to treatment for minor child. I hereby give consent to Journey 4 Hope Counseling Center, LLC to provide mental health services determined to be clinically necessary and appropriate for my child by a fully licensed provider. I understand that I may withdraw my consent at any time and may also refuse any services offered at any time.

Client/parent/legal guardian Initial: _____ Date: _____

Financial Release

I further understand that Journey 4 Hope Counseling Center may use confidential information about me in being reimbursed for services. I hereby consent for Journey 4 Hope Counseling Center to release information to consulting professionals, the area referring program and the funding source, _____, and for the funding source and area referring program to release information to Service Provider for this purpose. I hereby release Journey 4 Hope Counseling Center, LLC from all legal responsibility or liability that may arise from the release of such records.

Client/parent/legal guardian Initial: _____ Date: _____

Permission to Seek Emergency Medical Care

I hereby give consent for Journey 4 Hope Counseling Center to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that Journey 4 Hope Counseling Center will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/parent/legal guardian Initial: _____ Date: _____

Client Rights/Grievance Policies

I have received and had explained to me the Client Rights handout. I was verbally explained my rights as a client and understand that I may continue to seek information about these rights.

Client/parent/legal guardian Initial: _____ Date: _____

Confidentiality, Records & Privacy Rights

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Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored in a secure Electronic Health Records software known as Simple Practice which is HIPAA compliant and may be stored on an encrypted and secured electronic file stored on business devices. Additionally, your therapist will keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or others; (3) you report information about the abuse of a child, an elderly person, or disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that an appeal will be sustained, but we will do everything in our power to keep what you say confidential.
Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Minors & Parents- Clients under the age of 18 who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless the therapist believes that in doing so would endanger the child or there is an agreement otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is typically the agency's policy to request an agreement from parents that they consent to the child's right to confidentiality and limited access to their child's records (i.e. psychotherapy notes). If they agree, during treatment, the therapist will provide them only with general information about the progress of the child's treatment, attendance at scheduled sessions, and summary of their child's treatment when it is complete. Any other communication will include both the child and parents' consent, unless therapist feels that the child is in danger or is a danger to someone else, in which case, the parents will be notified of the concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and do their best to handle any objections the child may have.

I have received and explained to me the Privacy rights as detailed in the HIPAA policies. I was given a Notice of Privacy Practices handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/parent/legal guardian Initial: _____ Date: _____

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Therapist Role & Professional Relationship

Bring about Awareness
Help Define problems
Help Develop alternative responses, other options and resources in dealing with challenges.
Maintain the privacy of PHI and to provide notice of my legal duties and privacy practices with respect to PHI

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

I have read and understand the content above regarding my professional relationship with my therapist.

Client/parent/legal guardian Initial: _____ Date: _____

Privacy in Method of Contact

I understand that one of my rights is to be able to choose how I am contacted.

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Client's Name: _____ Insurance: _____ DOB: _____

I prefer to be contacted at_____

I prefer to have phone messages left for me at_____

Client/parent/legal guardian Initial: _____ Date: _____

I am aware that I am responsible for notifying Journey 4 Hope of any changes in my mailing address, telephone numbers, insurance and employment.

Please print, date and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist and you are authorizing your therapist to begin treatment with you.

_____ _____
Client Name (Please Print) Date

_____
Client Signature

If Applicable:

_____ _____
Parent/Legal Guardian Name (Please Print) Date

_____
Parent/Legal Guardian Signature

The signature of the therapist below indicates that she/he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Provider signature Date

First appointment is scheduled for: Date:_____ Time:_____