



Alabama Child & Adolescent Counseling Services

*****PLEASE KEEP THE FIRST 4 PAGES FOR YOUR RECORDS*****

Alexis Sapp, LPC, NBCC 1025 Montgomery Hwy Vestavia Hills, 35216

Informed Consent

This document has been provided as an explanation of the services I provide. The intent is to allow you to make informed and autonomous decisions pertaining to the counseling process.

Qualifications

I hold a Bachelor of Science in Psychology from the University of Alabama at Birmingham and a Master of Education in Counseling from the University of Montevallo. I am a National Board Certified and Licensed Professional Counselor in the state of Alabama. While I have significant experience and training, at times it may be necessary to refer a client to another professional more qualified in a certain area. If a referral is in order, I will inform you and discuss possible options. You may request to be referred to another counselor at any time.

Collaboration

The counseling process is a personal journey which ultimately results in the empowerment of the individual by focusing on choice, thoughts, perception, and behavior. It is a collaborative process between you and a counselor where mental health distresses and disorders are evaluated, assessed, and treated. For therapy to be most effective, it is essential that you/your child take an active role in the process.

Risks

The counseling process may open levels of awareness and provoke realizations that may cause uncomfortable feelings, sadness, guilt, anxiety, anger, pain, frustration, loneliness, and/or helplessness. These feelings can often be expected during the process towards relief and change.

Appointments

Sessions are generally scheduled in *60-minute* increments. Some situations may justify modification of the schedule, thus increasing or decreasing frequency of appointments. If you arrive late for your appointment, the session will still end at the normal specified time. If you need to cancel an appointment, please contact me at 205-530-8743 at least 24 hours in advance. **Cancelledations with less than 24 hours' notice will result in a full charge for the session.** I reserve the right to terminate the relationship if *two consecutive appointments* are missed without notification.

Fees and Payment

The initial intake session is \$115. The standard fee for a **60-minute individual counseling session** is \$105. Family Counseling Sessions are \$135 for a child and parent, \$155 for both parents, \$175 for both parents and child. Parenting Sessions are \$105 for a 40 minute session. We bill BCBS and ALLKIDS. We also accept cash, check or credit card. *Payment is due at the time of service.* Checks returned for insufficient funds may be subject to an additional \$35 fee. If you choose to pay by credit card a \$3.50 processing fee will be added to your card.

Groups/Family Counseling

Please understand that the Counselor encourages all information shared in groups consisting of consumers and/or family members be kept confidential. The Counselor cannot be held responsible if group members do not honor confidentiality of other group members.

Children/Adolescents:

In the state of Alabama a minor is a person under the age of 19 year old, unless such person has been emancipated. In the state of Alabama any minor who is 14 years of age or older may give consent for mental health services for him or herself. (Code of Alabama Section 22-8-4).

I want you to feel comfortable and safe in talking to me. Sometimes we will discuss things you do not want your parents or guardians to know about. This includes activities and behaviors that your parent/guardian would not approve of or would be upset by, **but** do not put you in serious or immediate harm.

However, there are exceptions to this rule. I will use my professional judgment in determining if I need to communicate to your parents or guardian any pattern of risk-taking behavior that becomes serious or harmful to you. If I feel that you present a threat of harm to yourself or others, either homicidal or suicidal ideations, I will need to communicate with your parents or guardian. If you reveal that you have been a victim of abuse, I am mandated by law to contact the Department of Human Resources (DHR).

Mandatory Reporting

Mandatory reporting requires me to report situations where the client is a danger to self or others, this includes suicidal or homicidal ideations. Situations in which a child, elderly, or disabled person is subject to abuse or neglect are also subject to mandatory reporting.

Termination

Termination of the counselor-client relationship can occur in several different contexts, but it is important that we be prepared for a termination phase from the outset of treatment. You can choose to terminate therapy at any time. You have a right to expect that the relationship will be terminated when you have realized maximum benefit from it, or have achieved the goals that are made at the outset.

Emergencies

In the event of an emergency for which you feel immediate attention is necessary, I will make reasonable effort to make myself available. If I am not immediately available and you reach voicemail, please leave a message indicating that the call is urgent. Please contact 911 immediately or proceed to the nearest emergency room for evaluation. If you need extra support but do not find yourself in an emergency, the Crisis Center Hotline is **205-323- 7777** locally, or **800-273-TALK** nationally.

If you (or your child) are referred to an emergency outpatient facility, such as the ER, we are not liable for anything that occurs at this facility. We are not affiliated with any hospital or emergency service; therefore we cannot guarantee any sort of outcome or treatment.

Electronic Communication

E-mail and voicemail may not be a secure/confidential means of communication. However they may be easy to access, and are acceptable means to communicate between therapist and client. In order to institute boundaries and safety in electronic communication in the therapeutic relationship, any electronic communication between therapist and client will be documented in the client's' chart. I will not engage with clients via social media through my personal profiles.

Confidentiality

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At ACA Counseling we utilize the online management software **Therapy Appointment** as our system to maintain client's PHI (personal health information). I may disclose PHI for the purposes of treatment, payment, and healthcare operations with your consent. You acknowledge that ACA Counseling has an administrative supervisor who may have access to your PHI. She may contact you concerning billing, scheduling, etc. You have signed this general consent to care, and authorize us to conduct payment and health care operations. You also authorize me to provide treatment and to conduct administrative steps associated with your care. Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement that you sign an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I speak with your physician about your treatment and/or medications.

There is a third, special authorization provision potentially relevant to the privacy of your records -- my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-patient in treatment settings, HIPAA permits keeping psychotherapy notes separate from the overall "designated medical record." Psychotherapy notes cannot be secured by insurance companies, nor can they insist upon their release for payment of services. Psychotherapy notes are my notes and are defined as follows: "notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session, and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes," which provide the following information about your care each time you have an appointment at my office: assessment/treatment, start and stop times, the

modalities of care, frequency of treatment furnished, results of assessments, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

You may, in writing, revoke all authorizations to disclose PHI at any time. You cannot revoke an authorization to disclose PHI that has already been disclosed. Uses and Disclosures Not Requiring Consent nor Authorizations. By law, PHI may be released without your consent or authorization in the following instances:

1. Child abuse
2. Suspected sexual abuse of a child
3. Adult and domestic Abuse
4. Health oversight activities (i.e. licensing boards investigations)
5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s). No information will ever be released for any sort of marketing purposes.

Patient's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your PHI. I may or may not agree to these restrictions, but if I do, they shall apply unless our agreement is changed in writing
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing.
- The right to inspect and receive a copy of your PHI in the designated mental health record set for as long as PHI is maintained in the record.
- The right to amend material in your PHI, although I may deny an improper request and/or respond to any amendment(s) you make to your record. For more information on how to exercise each of the rights, please do not hesitate to ask me for further assistance.

I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed. Current practices are applicable unless you receive a revision of my policies at a future time. My duties as a therapist include maintaining the privacy of your PHI, providing you with this notice of your rights and my privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

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5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers

Compensation, all of your care is automatically subject to review by your employer and/or insurer(s). No information will ever be released for any sort of marketing purposes.)

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- The right to inspect and receive a copy of your PHI in the designated mental health record set for as long as PHI is maintained in the record.
- The right to amend material in your PHI, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care.For more information on how to exercise each of the rights, please do not hesitate to ask me for further assistance.

I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed. Current practices are applicable unless you receive a revision of my policies at a future time. My duties as a therapist include maintaining the privacy of your PHI, providing you with this notice of your rights and my privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

Unless otherwise requested, records will be kept for 7 years before being destroyed

I have read, understood, agree, and consent to the above conditions of service. I have had the opportunity ask questions regarding the above policies.

Client Signature (14 years or older): _____ **Date** _____

Parent/Guardian of Client: _____ **Date** _____

Consent for Treatment of Minors Under the Age of 14

As parent/legal guardian and/or custodian I, _____, give

permission for my child, _____, to be counseled by Alexis Sapp, LPC, NBCC.