INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES FORM

Informed Consent for Therapy Services
Lisa Cottrell, LPC ~ Well Being Psychotherapy, LLC (WBP)

PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. In order to be clear about our professional relationship, please read and sign this document. 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.

PSYCHOLOGICAL 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 psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, rage, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy 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 finding resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy 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 therapy sessions. If you practice using the skills that I will teach you, you should see beneficial changes in your life.

The first few sessions will involve a comprehensive evaluation of your needs and treatment goals. By the end of the evaluation period, I will be able to offer you some initial impressions of what our work might include. We will discuss your treatment goals and together develop a plan for your treatment. You should assess 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 refer you to another mental health professional. It is important to feel like you and your therapist are a good fit.

APPOINTMENTS

Appointments will ordinarily be between 53 and 60 minutes in duration, typically once per week at a time we agree on, although sessions may be more or less frequent as needed. Trauma processing with EMDR or Brainspotting may at times require a 75 minute session.

The time scheduled for your appointment is assigned to you. **If you need to cancel or reschedule a session, I ask that you provide me with at least 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you will still be responsible for full payment for the appointment.** If you are using your insurance, it will be the amount of the insurance rate, not just your copayment or deductible. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will not be reimbursed. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES & PAYMENTS

As can be expected, my fees vary depending on the service provided and the amount of time spent providing counseling or other services. Payment may made by check, cash or credit card. There is a $5 service fee to cover the cost of credit card processing. We have discussed the current fees and you agree to pay for services provided. **You are responsible for paying in full at the time of your session unless prior arrangements have been made with me.** If any checks are returned for insufficient funds, you will be expected to fully reimburse me for any fees that I may incur. The returned check fee is typically $50. If you refuse to pay your debt, Well Being Psychotherapy, LLC reserves the right to use an attorney or collection agency to secure payment. If you wish to make alternative arrangements around payments, please discuss this possibility with me.

In addition to your appointments, it is my practice to charge an hourly amount on a prorated basis for other professional services that you may require such as report writing, phone conversations that last longer than 15 minutes (I will advise you before charging a fee,) attendance at meetings or consultations which you have requested (if I am available,) or the time required to perform any other service which you may request of me that I agree to perform.

PAYMENT & INSURANCE ISSUES

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment.

I am on a number of insurance panels. **If you want this office to file a claim with your insurance carrier, please provide me with your insurance information in advance.**

Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services.

If you plan to use your in-network insurance, you may want to contact your insurance carrier prior to our first session to determine your current deductible and copayment for a one hour outpatient therapy session. You will be responsible to pay any co-payments, coinsurance and deductibles at the time of service. Please bring your current insurance card to your appointment.

If I am not an in-network provider for your insurance company, you will need to pay me in full at the time of service. You will need to check to see if you have out of network benefits in your plan, if you intend to file a claim and I am not in your insurance network. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider in your network, I can help refer you to a colleague. If you would like to file a claim with your insurance carrier for any **out of network benefits**, please ask and I will provide you with a billing document of the services provided, dates of sessions, a diagnosis, and fees paid.

If a family member is going to assist you with treatment costs, they may choose to pay me directly. If so, I will need you to sign a consent for release of information form to speak with them about finances and continuation of therapy. Payment is required at the time service is provided.

PROFESSIONAL RECORDS

I am professionally required to keep appropriate records of the psychological services that I provide. The confidentiality of your records and our communications are protected by The Health Insurance Portability and Accountability Act of 1996. Your records are maintained in a secure, locked location. I keep records noting dates that you were here, your reasons for seeking therapy, the goals we set for treatment, your diagnosis, your progress, topics we discussed, conversations we had including things you said, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.

Your insurance company may ask me to provide additional clinical information such as treatment plans or summaries to justify your continued care. Any provided information will become part of the insurance company files. Insurers may share the information with a national medical information database.

You have the right to a copy of your medical file, except in unusual circumstances that involve potential emotional damage or danger to yourself. You may request a copy by completing and submitting a release form. Because these are professional records, it is possible that they may be misinterpreted or upsetting to untrained readers. For this reason, if you would like a copy, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents with

you. You also have the right to request that a copy of your file be made available to other health care providers when you request and sign a consent to release form.

CONFIDENTIALITY

Our relationship and conversations are **confidential with certain exceptions** listed below. Please remember that you may reopen the conversation about confidentiality at any time during our work together. Also, if I see you in public, I am happy to see you but to protect your confidentiality I will not speak to you unless you speak to me first. I will not tell the people that you are with how we know each other, but you may.

LIMITS OF CONFIDENTIALITY

At times, you may want to authorize me to provide diagnostic and treatment updates verbally or in writing to third parties such as your physicians, insurance company, attorney, or family members. You need to provide written or verbal consent for me to provide them any information.

If you provide written or verbal consent for me to release your confidential information to another party, then I may release the information that you agreed to release until you rescind such authorization in writing. Any disclosures of information prior to receiving your request to rescind your release are not effected by this action.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to share, or if I believe it will be helpful to you.

· Psychiatric Emergency: If you have indicated a desire to kill yourself, an intention to kill yourself, a plan to kill yourself, and you believe you will not keep yourself safe and alive, I am obligated to try to get you into a psychiatric inpatient facility immediately. I will share information with with the appropriate people to facilitate your admission. If you are seriously threatening to kill someone else, I am required to work to get you into a psychiatric inpatient facility immediately.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the Department of Child and Family Services. I am a mandated reporter of suspected abuse or neglect.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by law to immediately make a report and provide relevant information to the Department of Child and Family Services.

I may use contractors to assist with administrative functions. Contractors must sign a confidentiality and non-disclosure agreement. At times, I may confidentially discuss details of your care with a clinical consultant for clinical direction and assistance.

If you decide to communicate with me via text or email, by doing so you understand that these forms of communication are not secure. I suggest you restrict this type of communication to verifying appointment times. Text is the best way to reschedule.

CONTACTING ME

Feel free to call, text or email me to reschedule your appointment. Text is the best way to reach me. I am not usually immediately available by telephone. I do not answer my phone when I am with clients, after hours, on vacation, or when otherwise unavailable. At these times, you may text me, email me, or leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. I will try to reach you as soon as I can. If you are difficult to reach, please leave times you will be available. If you want me to use discretion when calling you or leaving a message for you, please let me know in advance.

EMERGENCIES

If you have an urgent psychological issue, please address it as directed below.

If you are having a psychiatric crisis and you feel unable to keep yourself safe, please leave me a message and then take one of these steps.

1) Contact the Georgia Access and Crisis Line at 1-800-715-4255, or
2) Go to your Local Hospital Emergency Room, or
3) Call 9-1-1.

Please text message me at 404-931-3066. Be aware that it will often take a while for me to get your message and respond especially during non-business hours.

If you are upset, but it is not an emergency, please use the skills that you have or will learn in therapy on how to handle distressing feelings. One online resource is for skills to tolerate distress can be found on DBT Self Help at www.dbtselfhelp.com.

If you are having a medical crisis, please call 911 or go to the E.R.

LEGAL CONCERNS

I am generally unavailable for legal cases. If you anticipate becoming involved in a court case, please let me know. **I recommend that we discuss** fully in advance any decision to waive your right to confidentiality and release your records to an attorney or court. Be aware that I do not participate in child custody or divorce cases and I do not provide expert testimony. I do not provide case management for clients on parole or probation. I

may refuse to comply with a request for records for legal proceedings. If a judge compels me to testify, you will be expected to pay for the professional time required. Because of the complexity and difficulty of legal involvement, I charge $300 per hour for preparation, consultation, and attendance at any legal proceeding.

SAFETY

As a precaution to ensure the safety of myself and my clients, no weapons of any kind are allowed in my office, including guns, knives, razors, etc. If you have a permit and carry a firearm, please leave it in your locked vehicle or at home. If you should become suicidal, I may require you to give your weapon to someone else for safekeeping until your mood and stability improve.

OTHER RIGHTS

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 expect that I will behave professionally as defined by the ethics of my profession. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

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. Your concerns will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist. You are free to end therapy at any time or take a break from therapy when you wish. In that circumstance, I would appreciate being notified of your decision to terminate therapy, as otherwise I will be concerned for your well-being. I will try to contact you if you miss an appointment. I generally hold a space for you until I know you have decided to stop coming. I would like to make that space available to others if you decide not to return. I am also ethically required to document your decision and the termination of our therapeutic relationship in your medical record. You are also welcome to return.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Informed Consent Agreement and Notice of Privacy Practices, understand its content and agree to these terms. Please keep the previous pages for your reference and provide this signed copy for our office records. Thank you.

_____ _____

Signature of Client/Patient Date of Birth

_____ _____

Printed Name of Client/Patient Date

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Signature of Psychotherapist