Sound Advice Counseling, LLC
LaShanna S Stephens, MS, LPC, NCC
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Macon, GA 31201
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INFORMED WRITTEN CONSENT FOR TREATMENT

PARTICIPATION IN PSYCHOTHERAPY TREATMENT:

Therapy is a voluntary relationship between people that works in part because of clearly defined rights and responsibilities held by each person. You may withdraw from treatment at any time without penalty and I, the therapist, reserve the right to terminate treatment if deemed ethically or clinically necessary. As a client in psychotherapy you have certain rights and responsibilities that are important for you to know about because this is YOUR therapy, with your well being as the goal. There are also certain legal limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

Therapy does not offer any guarantees. As we build a therapeutic relationship, I will offer my services to the best of my ability and I will expect that you put as much effort into the process as you expect to get out of it.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I am considered a provider or "covered entity." Under this federal law, as a requisite to treatment, you must also read and understand my "Notice of Privacy Practices." Without your signature on both this consent form and the Notice of Privacy Practices, I cannot treat you. The Notice of Privacy Practices further explains how HIPPA has impacted your right to privacy and my ability to use your mental health information for the purposes of treatment, payment, and health care operations.

MY RESPONSIBILITIES TO YOU AS YOUR THERAPIST:

1. **Confidentiality:** I am committed to maintaining strict confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your prior written permission (called "authorization for release of information form"). I will not even acknowledge you if I see you outside of the therapy room, unless you first acknowledge me. As the client, you control whether or not and to whom confidential information will be disclosed. If I am permitted to share information, I will always act so as to protect your privacy. If there is specific information that you DO NOT want me to share, please inform me and I will have you fill out the appropriate HIPPA forms that allow me to restrict what information might be shared for the purposes of treatment, payment, or health care operations. You may also revoke your permission for me to share information at any time. You may request anyone you wish to attend a therapy session with you.

   When the client is a minor, both parents (regardless of marital status or custody arrangements) have the right to be informed about their child's treatment, and I will typically encourage family therapy. However, the confidences shared in individual sessions by a child or adolescent will be respected so that an effective therapeutic relationship can be established.

With regards to couple, family, or group therapy, each of the clients present must, in writing, waive confidentiality before any records or information can be released. As well, if you and your partner or family members decide to have some individual sessions *as a part* of the couple or family therapy, what you say in those individual sessions will be considered to be a part of the couple or family therapy and can and probably will be discussed in our joint sessions. I am not a secret keeper and will encourage you and work with you to share your secrets with your partner or family members. I will remind you of this policy before beginning any individual sessions.

The following are legal exceptions to confidentiality mandated or implied by Georgia law. I will inform you any time that I think I will have to put these into effect:

1. If I have good reason to believe that you are abusing or neglecting a child, adolescent, or elder, or if you give me information about someone else that is doing this, I must inform the Division of Family and Children Services by calling the GA abuse hotline at 1-855 GACHILD.
2. If I have good reason to believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police to have you taken to the local crisis stabilization unit. I will explore all other options with you before I take this step.
3. If I have good reason to believe that you will harm another person, I may attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
4. When there is a valid court order compelling records or witness testimony. I will attempt to obtain written permission from you when possible regarding the release of these records and we can also discuss obtaining a protective order to help maintain confidentiality of records. Please let me know if you are in this kind of situation so that I can take the utmost care in protecting your privacy.

*HIPPA has different conditions that allow for me to share or disclose your mental health information with or without your permission (these are outlined in the Notice of Privacy Practices). Many of these conditions would violate Florida Law if I followed them. Thus, I will uphold the law (state or federal) that is stricter in favor of protecting your mental health information and your right as a client receiving therapeutic services.

2. **Records and Record-keeping:** I normally keep records with a brief summary of each session (i.e., who, when, and what was discussed) called a “progress note.” If your records are requested, I normally submit a summary of the record to the requesting party. You have the right to see your record at any time. If you request a copy of the record, there will be a charge of 25 cents per copied page. The physical record is the property of my counseling office and I will maintain your record in a locked, secure location for a minimum of 7 years, according to GA law.

3. **Diagnosis:** If a third party, such as an insurance company, is reimbursing you for part of your bill, I am normally required to provide a diagnosis in order for the third party to pay. Diagnoses are technical terms that describe the nature of your problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-IV; I have a copy in my office and will be glad to let you review it and answer any questions that you may have with regards to its descriptions.

4. **Training, credentials, and ethical regulations:**
   - **a.** I have MS in Counseling/Psychology from the University of West Alabama. I am a Licensed Professional Counselor in the state of Georgia and a National Certified Counselor through the National Board of Certified Counselors (NBCC). I am also a certified Prepare/Enrich facilitator. I am also a member the American Association of Christian Counselors (AACC).
   - **b.** I use a variety of techniques in therapy, trying to find what will work best for you. I may suggest that you consult with a physical health care provider, another therapist, or participate in a therapy or support group as

part of your work with me. I will provide appropriate referrals as necessary. You have the right to refuse anything that I suggest without being penalized in any way.

c. In addition to the laws and rules governing my clinical behavior, I am also ethically bound to the ACA Code of Ethics. You may obtain a copy of this code by contacting ACA through their website at www.counseling.org. Legally and ethically, I do not engage in social or sexual relationships with clients or former clients.

d. There are times when I consult with professional colleagues to gain greater insight and feedback for my work. If I consult on my work with you, I will not use your name or any information that can identify you. If you feel that I am in need of getting better information about a topic of concern to you, please let me know; I am always open to your suggestions and concerns.

5. **Out of the office:** If I am going to be away from the office for an extended period of time, I will tell you well in advance. I will also provide you with the name and phone number of the therapist covering my practice. If you have an emergency in between sessions or while I am out of town, you are first encouraged to call 911.

6. **After–hour's emergencies:** If you have an emergency after hours you must first call 911. The police will need to escort you to the crisis stabilization unit. Then you may contact me and let me know where you are and how you can be reached. If you are not having an emergency, please reserve all other information for our next scheduled appointment.

YOUR RESPONSIBILITIES AS A THERAPY CLIENT:

1. You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without providing notice. you must pay for that session at our next scheduled meeting. If this happens regularly, we will discuss how it is impacting the therapy process. The only exception to this rule is if you find yourself in an emergency situation and cannot call or would endanger yourself by attempting to come to the session.

2. You are responsible for making your payment at the beginning of each scheduled session. This is so that we can end the session on a therapeutic note. Your fee is based on a 60-minute session. Please refer to the "FEE AGREEMENT" for more specific information regarding payment. You are responsible for the investment you choose to make in the therapeutic process.

3. I do file some insurance and am on panels of some EAPs. If I am not a provider for your insurance, I will provide you with all the necessary information you will need to file your claim. Please inform me if you need any other specific information that I do not automatically provide on your session receipt. All fees are due up front; any reimbursement you receive from your insurance company is to be kept by you.

4. I am not willing to have clients run a bill. If you find that you are having a hard time paying for therapy, please discuss it with me. I have a percentage of slots in my practice reserved for lower-paying clients, and if one of those is open, I will make it available. Or, we may meet less frequently. If your financial circumstances improve, please let me know so that I could make the reduced-fee slot available to someone else. I can also provide you with other counseling agencies that provide therapy on a sliding fee scale. I cannot ethically accept barter for therapy. If you accumulate a debt and eventually refuse to pay it, therapy will be terminated and I reserve the right to give your name and the amount due to a collection agency.

CONSENT FOR TREATMENT OF MINORS (if applicable):

I/We, ______________________________________, the parent(s) of _____________________________________, give LaShanna S. Stephens, MS, LPC, NCC permission to provide psychotherapy services to my child. I recognize that I have a duty to be reasonably available to provide consent to changes in my child's treatment and to participate in treatment as deemed necessary and appropriate.

In the event of separation or divorce, it is understood that **BOTH parents, regardless of custody, must sign this form **BEFORE** services can be rendered to a minor. (A notarized original may be sent by mail). As well, documentation of the custody arrangement must be provided and a copy will be kept in the file.

EMAIL & TEXT MESSAGE COMMUNICATION:

Email and text messaging have become a common form of communication in our culture. It is my responsibility to inform you that your confidentiality cannot be guaranteed when we communicate this way. My computer is protected with virus protection and firewall, but communications via the Internet or via a cell phone are always vulnerable.

Please initial below, beneath the signature lines, if you wish to communicate via email, or text message. By initialing, you acknowledge that you understand the vulnerability inherent in these communications but accept that they are a way of life and are convenient ways to schedule and reschedule appointments, provide updates, journal entries, and other information that can assist you in therapy. Any communications between us will be printed and kept in your file as a part of your therapy record.

CLIENT CONSENT TO PSYCHOTHERAPY SERVICES:

I HAVE READ THIS STATEMENT, HAD SUFFICIENT TIME TO BE SURE THAT I CONSIDERED IT CAREFULLY, ASKED ANY QUESTIONS THAT I NEEDED TO, AND I UNDERSTAND THE INFORMATION OUTLINED ABOVE. I HAVE REQUESTED A COPY, IF I WISH, OF THIS AND ANY OTHER FORM I HAVE SIGNED. I CONSENT TO HAVE THE NECESSARY INFORMATION RELEASED IN ORDER FOR ME TO FILE AN INSURANCE CLAIM. I UNDERSTAND MY RIGHTS AND RESPONSIBILITIES AS A CLIENT, AND MY THERAPIST'S RESPONSIBILITIES TO ME. WITH THIS UNDERSTANDING, I AGREE TO UNDERTAKE THERAPY WITH LaShanna Stephens, MS, LPC, NCC.

Client Signature: ____ Date: ____________

Client Signature: ____ Date: ____________

Parent(s) Signature (or legal custodian) if treatment is for a minor child:

____ Date: ________________

____ Date: ________________

Please initial:

___________ **I/We acknowledge that I have received a copy of this form.**

___________ **I/We acknowledge that I have refused a copy of this form.**

PLEASE INITIAL BELOW *ONLY IF* YOU AUTHORIZE COMMUNICATION VIA EMAIL OR TEXT MESSAGE:

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