THE ATLANTA COUNSELING GROUP LLC

INFORMATION, DISCLOSURE, AND CONSENT FORM

Welcome to the Atlanta Counseling Group. We commend you for taking steps toward self-care for yourself, your family member, and/or your relationship. Counseling or the therapeutic process begins with an assessment to identify and clarify your primary needs. This process may require one or more sessions. If you or your therapist determine that your needs fall outside the therapist's training, the therapist will assist you to find a better suited therapist if you so desire. A treatment plan established from the needs assessment and agreed upon by you and your therapist will guide the therapeutic process.

Counseling and psychotherapy are used interchangeably to indicate forms of therapeutic sharing that address various personal and family issues such as depression, anxiety, marital, family, and other challenges. Effective counseling can result in meaningful life changes based on a greater insight into your psychological self and your personal, interpersonal, and social circumstances. Effective counseling depends upon your willingness to share openly and honestly. Please inform your therapist if at any time you experience discomfort relative to sharing openly and honestly. All feelings are worthy of voicing and discussing. Our counseling approach is based on best practices and we adhere to standards and ethical guidelines of state licensing laws and professional associations.

CLIENT RIGHTS & CONFIDENTIALITY

The state of Georgia has established your clinical practices rights. These include: consent for treatment, disclosure of therapist qualifications, referral request to a different therapist, ending treatment, accessing the client grievance procedures, and the confidential handling of treatment records.

Information you share with your therapist is confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, or as part of the professional practice of this center. **There are legal circumstances when the therapist must report shared information to appropriate persons or agencies, for example: a) if you threaten grave bodily harm or death to yourself or someone else; b) if you reveal information about child, elder, disabled or dependent adult, or parental abuse; or c) if ordered by a court of law.** Courts may subpoena treatment notes. Otherwise, written permission is required before your therapist can share treatment information. We maintain high clinical standards in our assessment, treatment, case records, business operations, and quality control.

It is important that you inform us at the outset if your counseling is court-ordered or in any way related to current or anticipated legal proceedings, i.e. divorce, child custody or litigation or any legal matter; the seeking of disability or medical leave matters. Failure to inform of current or anticipated legal proceedings will lead to termination of therapy.

CANCELLATIONS, INCLEMENT WEATHER, & EMERGENCY CONTACT INFORMATION

Unless you experience an emergency, it is important that you **inform your counselor 24 hours in advance when you cannot honor an appointment. Failure to do so may result in a $75 cancellation fee. Please initial the blank below to indicate that you will honor the cancellation policy.**

_____(Please initial)

In case of inclement weather, you and your therapist may arrange a telehealth session in lieu of a face-to-face session, if agreeable to you both. Your therapist will provide you with a voicemail, contact phone number, and or link and will inform you of his/her availability in case of an emergency. In the event of a mental health emergency, **call 911 or proceed to the nearest hospital emergency room**.

FEES, INSURANCE, & PAYMENTS

Our fee range is $140 to $175 per session. Please plan to submit payment prior to or after each session. Cash, checks, credit and debit cards are accepted. Clients will be required to pay returned check charges if a financial institution returns a check as unpayable.

At the discretion of your counselor, uninsured clients or clients who choose not to use their insurance may pay an adjusted fee based on total household income. Adjusted fees will be discussed, agreed upon, and recorded during the first session.

If you use insurance or a other third party coverage, please inform us prior to your first session. When possible, please contact your insurer to determine your deductible and/or co-pay prior to your first session. You may download and complete our **Insurance Verification Form** to assist with this process. ACG will file your claims once we have accurate and complete information on file. ACG cannot guarantee that your insurer will pay your claim. You are responsible for balance in the event that your insurer or third party payer does not honor the claim submitted on your behalf.

CONCLUDING THERAPY

You may terminate counseling at any time. We ask that you conclude your counseling with a face-to-face appointment.

General Consent to Therapy (Please initial the following applicable statements):

___ I have read and agree to adhere by the **Information, Disclosure and Consent Form**.
___ **I consent to treatment as described and understand that sessions are 45 to 55 minutes.**

___ I agree to the fee of _____ and will pay for my therapy expenses as described above.
(Unless pre-discussed, you may leave blank and discuss with your therapist.)

___ **I authorize the release of healthcare information necessary to process claims generated by ACG.**
___ I hereby authorize payment directly to ACG of any benefits due me for counseling/psychotherapy.

___ **I understand that I am responsible for any amount not covered by my insurance.**
___ I have read ACG's **Confidentiality & HIPAA Practices** and authorize ACG to utilize encrypted and unencrypted email to communicate non-sensitive information with me.

Signature _____ **Date** _____

Printed Name _____

Signature _____ **Date** _____

Printed Name _____

Parent or Legal Guardian of a Minor

Signature _____ **Date** _____

Printed Name _____

Interaction with Legal System

I will not involve or engage my counselor/therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This includes any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system.

In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record. If I believe it necessary to subpoena my therapist, I will be responsible for his or her expert witness fees in the amount of $1000 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $250 per hour including travel time.

I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

Non-Recording Agreement

I will not audio or video record sessions. Doing so can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all persons involved. Client recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government.

The Atlanta Counseling Group LLC maintains a strict policy against audio and video recording. Atlanta Counseling Group therapists will consent to recording of a session only for exceptional reasons, after drawbacks and risks have been discussed, and the benefit clearly outweighs them. Violation of this policy by covert recording or non-conformance with this agreement will lead to termination of therapy.

My signature below acknowledges that I have read, understand, and will adhere to the *Interaction with Legal System* and *Non-Recording* policies.

Signature _____ **Date** _____

Printed Name _____

Signature _____ **Date** _____

Printed Name _____

Parent or Legal Guardian of a Minor

Signature _____ **Date** _____

Printed Name _____