



Supportive Solutions, LLC

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INFORMED CONSENT AND PERMISSION TO PROVIDE ASSESSMENT AND/OR TREATMENT SERVICES

1. What is Informed Consent?

(Initials) This document describes Supportive Solutions treatment policies, fee structures, and your rights. It is designed to help you make informed decisions about whether or not to accept and proceed with counseling services.

2. Major Functions and Services Provided by Supportive Solutions, LLC

(Initials) Specialized treatment and services for individuals, couples, and families:

- A. Assessment of the presenting problem
- B. Individual, Family and/or Group psychotherapy (face to face and/or Distance Counseling)
- C. Therapeutic parent training and education
- D. Adjunctive therapy/consultation with other therapists involved with Client's care
- E. Workshops for Professionals and Parents
- F. Referral to national and community resources for assessment and/or treatment not provided by Counselor (i.e., psychological/neurological evaluations).
- G. Client/Family advocacy
- H. Collaboration and consultation with other agencies involved with Client care
- I. Current information and resources on presenting problem.

3. Client Involvement

(Initials) Your involvement in the process will be to increase your awareness of the problem, make a clear plan to address the problem, and focus on what you can do to improve the situation and reach your goals. When complete information is shared the process is more effective. Appropriate assistance cannot be provided if your Counselor is unaware of challenges or information. Your progress in therapy is indicated more by what skills you practice in between sessions than what happens in the session.

4. Treatment Outcomes

(Initials) No treatment intervention can effectively guarantee a successful outcome for any individuals who have a current challenge. The earlier treatment is pursued, the better the long-term prognosis.

5. Office Hours and Appointments/Missed Appointments

(Initials) Appointments are scheduled in advance and are attended in a timely manner. Typically sessions are 50 minutes long held approximately once a week or as otherwise agreed upon. When you book an appointment, you are contracting for professional time and services. The cancellation policy requires **24 hours advance** notice as each scheduled appointment involves preparation time before and after as well as time spent in session. If you do not cancel your appointment within the 24 hour minimum time period, you will be charged the **full session fee**.

6. Fee Structure:

(Initials) ****Services rendered outside of session time are billed separately under the Counselor's Fee services include: phone consultation, emails, requests for documentation, or letter writing****

No Counselor can guarantee a successful treatment outcome with a particular Client. Therefore, fees are paid as a consideration for the specialized therapeutic interventions and not for particular results for any Client. Payment for service are the sole responsibility of the Client and/or Family and is **due at the time services are rendered**.

Insurance claims can be submitted to any insurance company that Supportive Solutions is an in-network provider. This requires an exchange of information with your insurance company and

includes dates of visits and a clinical diagnosis to justify the services by identifying your current needs. For individuals who wish to independently submit a claim for out of network benefits, a receipt for services can be provided to the family for tax documentation purposes and to seek insurance reimbursement.

Forms of payment accepted include personal checks, cash, and credit cards; in the event that a check is returned for insufficient funds or a credit card is declined, the Client is responsible for payment plus **\$25.00** fee.

7. **Clients' Rights**

(Initials)

A. **Confidentiality:** Counselors will respect the privacy of Clients and hold in confidence all information obtained in the course of professional service. Information can be shared with other professionals and individuals **only when an Authorization for Contact has been signed by the Client or when the Counselor needs to seek the advice and counsel of colleagues and supervisors when such consultation is in the best interest of the Client and all identifying information is kept confidential.**

In couples and family therapy, or when different family members are seen individually, **confidentiality and privilege do not apply** between the couple or among family members. Clinical judgment will be used when revealing such information. Records will not be released to any outside party unless Supportive Solutions is authorized to do so by all adult family members who were part of the treatment or unless compelled to do so by law or a valid court order.

Limits of Confidentiality: ALL mental health service professionals are mandated to report the following situations where confidentiality and privilege are exceptions:

1. Any and all allegations of sexual abuse, physical abuse, or neglect of a child, disabled person, elderly individual, or someone who is vulnerable and unable to leave place of abuse. Georgia Law requires that all allegations of abuse be reported to law enforcement or the Department of Family and Children Services in the county where the Client lives.
2. A situation where a Client poses a danger to self (suicidal thoughts) or others.
3. Mental Health professionals are also bound by the **Duty to Warn**, If you make threats of violence toward a third party or when a third party has made threats of violence toward you. In the case of a third party threatening violence toward a Client, Counselors will contact legal authorities and make all **reasonable attempts** to inform you of such threats and the same holds true to an identified individual that a Client makes statements to harm.
4. Information is also not considered confidential when Mental Health Professionals are considered a Defendant in a civil, criminal, or disciplinary action. In addition, **all Client records are subject to court subpoena at all times.**
5. Client(s) voluntarily waive any and all confidentiality if he/she commits a crime against Counselor, Counselor's property, or on the Counselor's office premises. Counselor will report the crime to the police authorities and will press charges to the full extent of the law.
6. Billing Procedures: When your insurance company is involved for the purposes of filing a claim, insurance audits, case reviews or appeals, and other relevant insurance situations.
7. When otherwise required by law or natural disasters where protected records may be exposed.

B. Litigation Limitation: Therapy sessions are used as a safe place to make full disclosures of information that are confidential in nature. The nature of legal proceedings makes it difficult to maintain confidentiality. It is agreed that should there be a legal proceeding such as divorce, custody disputes, injuries, lawsuits, etc. that neither you as the Client or your attorney will ask me to testify in court or at any other proceedings nor will a disclosure of psychotherapy records be requested.

C. Primacy of Client's Interests: Primary responsibility is to the Client. Every reasonable effort will be made to advance the welfare, best interest, and advocate for you at all times.

D. Ending of Services: Services typically end when treatment goals are complete and you are feeling better. You have the right to end assessment or treatment at any time. If the treatment is being ended against professional advice, you will be advised to continue treatment and intervention and written referrals will be provided upon request to another appropriate treatment source. If you wish to end services prematurely, every reasonable attempt will be made to terminate treatment as constructively as possible. **Counselor reserves the right to end the Counselor-Client relationship immediately in the event the Client threatens Counselor, Counselor's family, Counselor's colleagues or anyone else in the office.**

E. Grievance Procedures: If you have a concern please address this with your Counselor directly. In the event the concern cannot be satisfactorily resolved, your Counselor will provide you the licensing board contact information.

8. The Nature and Extent of Record Keeping

(Initials)

A file will be maintained to document information about therapy sessions and any work provided on behalf of you as the Client. Georgia law requires records to be kept for the period of seven (7) years and an additional three (3) years beyond a person's "legal" age of 18 in Georgia. This means written records involving a child will be preserved until the person is at least 21 years of age. Records are securely stored and in the event something happens to your Counselor, arrangements have been made to have your files secured by another professional in practice.

9. Client Emergency Contact Information:

(Initials)

My emergency contact person is _____,

Relationship: _____ Contact Number: _____

IN CASE OF LIFE THREATENING EMERGENCIES INDIVIDUALS SHOULD:

- **CALL THE GEORGIA ACCESS AND CRISIS LINE AT 1-800-715-4225**
- **GO TO THE EMERGENCY ROOM OF THEIR LOCAL HOSPITAL**
- **CALL ATLANTA EMERGENCY MENTAL HEALTH SERVICES AT 404-730-1600**
- **CONTACT A FACILITY THAT OFFER 24 HOURS A DAY/7 DAYS A WEEK ADMISSION FOR ASSESSMENT AND CRISIS SUPPORT: RIDGEVIEW INSTITUTE: 770-434-4567 www.ridgeviewinstitute.com
PEACHFORD HOSPITAL: 770-455-3200 www.peachfordhospital.com**

Distance Counseling Options & Confidentiality of E-mail and Chat, Cell Phone and Fax Communication:

-If you choose to email from your personal email account, please limit the contents to housekeeping issues such as cancellation or change in contact information. Personal and clinical concerns should not be addressed via regular email. You understand that emails between sessions that contain confidential information should be sent utilizing encryption. If you wish to use email as a way to "journal" information between sessions, you understand that your Counselor may not have the opportunity to review your journal emails until the next scheduled session. **Electronic communication is not a way of communicating new information regarding care or of communicating emergency treatment needs.** You must call and talk to your Counselor regarding any information towards your treatment that would be deemed an emergency.

-Any computer files referencing our communication are maintained using secure and encrypted measures.

-You as the client understand that phone and email sessions have limitations compared to in-person sessions or video sessions, among those being the lack of "personal" face-to-face interactions, the lack of visual and audio cues in the therapy process.

-You understand that telephone/online psychotherapy with Supportive Solutions is not a substitute for medication under the care of a Psychiatrist or Doctor.

-You understand that online and telephone therapy is not appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. As stated previously, if a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911, or go to a hospital emergency room.

-You also understand that your Counselor follows the laws and professional regulations of the State of Georgia (USA) and the psychotherapy treatment will be considered to take place in the State of Georgia(USA).

Every effort will be made to keep all information confidential. If we are working online together, your Counselor asks that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. Please communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If you and your Counselor are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes.

I acknowledge that if I use electronic mail to initiate contact with Supportive Solutions regarding my therapeutic care, the Supportive Solutions Staff and/or his/her representative has my permission to correspond via that email address and other forms of electronic communications. I give permission for a clinical staff member to email me regarding basic appointments and administrative communication:

_____ @ _____

I give Supportive Solutions my permission to add my e-mail address for the purpose of sending me notices of future events and other pertinent information through my email.

_____ **10. Social Media Policy/ Counselor's Blog:**

(Initials) Clear and healthy boundaries are necessary for strong therapeutic work. Individual Counselors working with Supportive Solutions, LLC may not make online connections with current or past clients through any social media outlet including but not limited to: Facebook, Twitter, LinkedIn, Snap Chat and Instagram. In the event a client attempts to connect online, the Counselor may not accept the request and will discuss the matter further in session.

Your Counselor may maintain a blog or publish articles at times in attempts to educate others regarding a variety of topics. You are able to subscribe to the blog, but may not post a response as it may compromise your confidentiality.

1. I have read and understand all of the information contained in this informed consent and all of my questions have been answered to my satisfaction.
2. I hereby grant my permission for any audio-visual recordings and/or photocopying of artwork to be used for supervision and case consultation in treatment, I will be informed prior to any recording taking place in session.

Client's Signature

Client's Name (Please Print)

Date

Counselor's Signature and Title

Date