**INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT**

 I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

**Confidentiality & Records**

 Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a “Release of Information” form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed “privileged communication.” Privileged communication is your right as a client to have a confidential relationship with a therapist. If for some reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

 *Please note that in couple’s and family counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner or family member.*

**Confidentiality & E-mail and Facsimile**

I am available to communicate on a limited basis through e-mail. Please note that I will communicate via email for cancellations, appointments, or general questions, but I cannot guarantee that the information contained will remain confidential. I will take every precaution to keep my computer protected and concealed from others, but I cannot control what happens in cyberspace, nor what happens to my e-mail messages once they reach you. Please keep this risk in mind before sending e-mail correspondence. Be aware that faxes are not a fully protected form of communication. If you want to be certain that your communication with me is completely confidential, phone and postal mail are the best ways to do that.

**Structure and Cost of Sessions**

 I agree to provide individual sessions for the fee of $110 per 50-minute session. Adult psychotherapy groups are paid for by module at $30 per person per group (normally 1.5 hours per group unless otherwise specified). Telephone calls and e-mails that exceed 10 minutes in duration will be billed at $2 per minute. If the call or e-mail should take up to 50 minutes, the full session fee will be billed. Doing psychotherapy by phone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you.

 The fee for each session will be due at the conclusion of the session. If you should need a letter (such as for court) you will be charged for the time taken to produce the document. In most cases, this is the same as the fee for a 50-minute session. Cash, personal checks, and credit cards are the forms of payment, and I will provide a receipt of payment either printed for you at the time of payment or emailed to you. The receipt of payment may also be used as a statement for insurance or out-of-network benefits if applicable to you. Please note that there is a $25 additional fee for any returned checks.

 Insurance companies have many rules and requirements specific to certain plans. It is your responsibility to find out your insurance company’s policies and to file for insurance reimbursement. I will gladly provide you with a statement of services for your insurance company and to assist you with any questions you may have in this area.

**Cancellation Policy**

 In the event that you are unable to keep an appointment, you must notify me by phone call at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the full fee of the session you missed. Please note that I do not make any exceptions to this policy even for unexpected illness. Thank you for understanding that this policy is not personal, but a business necessity. Please note that insurance companies do not reimburse for missed sessions. Therefore, as stated above, if advance notice for cancellation of an appointment is not received at least 24 hours in advance, you will be financially responsible for my session full fee ($100) out of pocket. Your copay will not apply in this situation.

**Professional Relationship**

 Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client’s interests, and then the client’s (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

 Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

 You should also know that therapists are required to keep the identity of their client a secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

**Confidentiality with Children and Teenagers**

 Teenagers and children will rarely be completely open with a counselor unless they believe that they have privacy in the therapeutic sessions. It is important that parents agree with the concept of their child having confidentiality in their counseling sessions. If I believe your child is at risk of harming himself/herself or harming another person, I will disclose this information to you.

**In Case of an Emergency**

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I am not available at all times by telephone or email. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I am in the office every Tuesday, Thursday, and every other Saturday. I will probably not be able to answer the phone when with a client. When I am unavailable, my telephone will be answered by voicemail. Generally, I will return phone calls within 24 business hours with the exception of Sundays, Mondays, and holidays. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

* Call Ridgeview Institute at 770-434-4567 or Peachford Hospital at 770-455-3200.
* Georgia Crisis & Access Line at 800-715-4225.
* Call 911 or go to your nearest emergency room.

**Terms of Therapy**

*Please read and initial each statement below:*

There is a session fee of $110 for a 50 minute session with Lavinia Myers, MA, LPC paid via cash, check or credit card. Family therapy may be billed at an increased rate. Payment is due at the time of service.

*I understand and agree \_\_\_\_\_\_*

There is a fee of $30 per Adult Psychotherapy Group, payment for group is made per group session and is paid via cash or check. Payment is due at the end of each group session.

*I understand and agree \_\_\_\_\_\_*

There is a requirement of 24 hour notice of cancellation of your appointment; otherwise you will be charged a missed appointment fee equal to the session fee. Payment for the missed session must be made promptly to ensure keeping your time slot for the following week.

*I understand and agree \_\_\_\_\_\_*

Medical and psychiatric emergencies are life-threatening events that require prompt medical treatment – call 911 or go to your nearest emergency room. If the emergency is psychiatric you can also call Ridgeview Institute at 770-434-4567 or Peachford Hospital at 770-454-5589 or the Georgia Crisis & Access Line at 800-715-4225.

*I understand and agree \_\_\_\_\_\_*

In order for therapy to be the most beneficial, you are encouraged to be medication/treatment compliant (all prescribed medications/treatments) and keep all appointments with your treating physicians (psychiatrist and other medical doctors).

*I understand and agree \_\_\_\_\_\_*

There is no charge for a phone consult lasting less than 10 minutes. Any calls or email responses over 10 minutes in length are charged at $2.00 per minute.

*I understand and agree \_\_\_\_\_\_*

I am not a medical doctor. While medication compliance will be discussed, all medical concerns must be addressed by your doctor.

*I understand and agree \_\_\_\_\_\_*

Chemical dependency and eating disorder behaviors greatly reduce the effectiveness of therapy. Clients are to actively work on recovery while in therapy with Lavinia Myers.

*I understand and agree \_\_\_\_\_\_*

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you.

Your signature below also acknowledges that you, the undersigned Client/Guardian, have received and read a copy of Lavinia D. Myers’ "Notice of Privacy Practices" (NPP), that you understand that Lavinia D. Myers, MA, LPC may utilize the Client’s Protected Health Information (PHI) in the ways described in the NPP. The Client has retained a copy of the NPP.

Client’s printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Signature Date

If Applicable, Legal Guardian’s printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Signature Date

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