Patient's Name: _____

ADVANCED COUNSELING SERVICES

Liberate ▪ Empower ▪ Transform

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CONSENT TO TREATMENT

Welcome to Advanced Counseling Services where we are transforming lives through the empowerment and liberation of the people. We thank you for choosing our practice for your therapeutic needs. We look forward to assisting you. This document provides information regarding your treatment as it relates to expectations, confidentiality, emergencies, and other various details.

This document is called "an informed consent" which means you are being informed "in writing" of the various aspects concerning your treatment. It is a legally binding document. In order for us to proceed with your treatment, we will need your "consent" to do so. If after having read the contents of this document you would like to continue with our services, please provide your signature and today's date on the last page. Your signature acknowledges that you have received, read, and understood the contents of this document **prior to** receiving services. **Please initial here of your receipt of this document prior to services: _____**

Education, Qualifications, Experience, and Scope of Practice

We are to inform you of our qualifications, experience, and scope of our practice. Ms. Morris received her Master of Arts in Counseling Psychology from Argosy University in 1995. She has been a Licensed Professional Counselor (LPC) by the State of Georgia since 2003, and her license is currently active. She holds an IC&RC certification as a Co-Occurring Disorders Professional. Since 1995, she has worked for several agencies such as Atlanta Union Mission, Families First, Dekalb Community Service Board and various other private agencies. In 2007, she provided services as an independent contractor in a group practice setting until 2011 when she began her private practice. She provides professional trainings for such organizations as NAMI, GACA and GARR. Her group practice experience afforded her the opportunity to work with one of the top 10 psychiatrist in the State of Georgia with whom she continues in partnership with. Her therapeutic style is direct, didactic, progressive, engaging and dynamic. Please see our website for more information concerning her background and scope of practice @ deloresmorris.com.

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Protected Health Information(PHI)

(You may request to restrict how your personal information is used or disclosed)

Records: Documentation of your treatment process is a part of your clinical record. We are to inform you of the manner in which we provide protection of your health information. Your PHI is secured via our electronic health record (EHR) system in a virtual location within a cloud-based infrastructure (online). This system maintains stringent security measures to ensure your privacy.

Confidentiality: You have a right to confidentiality except for the following:

(except means , these WILL NOT be kept confidential)

(1) If you are a danger to yourself, your therapist is obligated to follow the necessary protocols and notifications to ensure your safety. If you are a danger to others, your therapist has a **duty to warn** the person or persons, as well as the appropriate authorities.
(2) Any disclosures made in regards to the neglect and abuse of a child, an elderly person, or a disabled individual, your therapist is a mandated reporter and by law must notify the appropriate authorities (i.e., DFCS, etc.).
(3) Consult with your attorney in regards to situations that may result in your protected health information to be subpoena by a judge as these situations may or may not afford you therapist-patient privileges.
(4) In the event of case consultations, only general information will be disclosed.
(5) In the event disclosure becomes necessary in a medical emergency, police intervention, audits of medical records, and program evaluations, or for insurance purposes.
(6) In the event of disclosure regarding prenatal exposure to controlled substances and illegal drugs the appropriate authorities must be notified.
(7) In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records.
(8) Colleagues must report misconduct of other colleagues in which related patient records may become necessary to substantiate disciplinary concerns.
(9) Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records.
(10) In the event a collection agency is utilized, the appropriate billing information may be disclosed.
(11) Violations of Federal and/or State laws may be reported.
(12) "Secrets" are not protected (i.e., active infidelity, etc.) and may result in disruption of services if left unaddressed.

If you have any questions regarding these "limits to confidentiality", please ask

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Fees and Expectations

The first 2-3 sessions are for the assessment process. Several forms and routine questions are a part of this process. These procedures will assist us in determining the appropriate level of care for you. Next, you will work with your therapist to determine a focus for therapy and establish goals and objectives. Be patient in the processes and understand that change does not happen overnight.

a. **Insurance:** If you plan to use your insurance for payment, please read our Financial Policy carefully as you are still responsible for payment in the event your insurance does not reimburse for services rendered.

b. **Copay:** Copayments are a requirement of your insurance policy and are due at the time of services. If you are unable to make your copayment, please discuss with your therapist.

c. **Deductibles:** Deductibles are the primary reason patients receive a billing statement. It is your responsibility to know the benefits of your plan.

d. **Authorizations:** Some insurance companies require a prior authorization for services. This is usually the second reason patients receive a billing statement. While we provide the courtesy of verifying your insurance coverage and benefits, it is your responsibility to verify your coverage, benefits, and protocols for services. We are not responsible for the decisions and determinations your insurance company makes that may result in a patient billing statement. Nor are we responsible for omissions of verification that may result in a patient billing statement.

Fees, Method of Payment, and Cancellations

Payment: Cash, personal checks, debit and credit cards are acceptable forms of payment. Make your check payable to Advanced Counseling Services. You have the option of making your check payable to Delores Morris for confidentially purposes. **Fees:** There is a $30 fee for returned checks. There is a $25.00 fee for paperwork completions (i.e., disability, letters, FMLA, etc.) and a $25.00 fee for missed appointments. Sliding scale fees when paying out of pocket range from $40.00 - $85.00. Payment plans are available. Individual sessions are $110.00. Couple sessions are $150.00. Group sessions are $40.00 per group per person. Family sessions are $150.00. Off-site school interventions are $75.00 plus mileage (.52). **Cancellation Policy:** In the event you are unable to keep an appointment, please notify us within 24 hours to avoid fees for late cancellations.

Emergency Options:

Generally, phone calls are returned within 24-48 hours during normal business hours; and weekend calls (Saturday and Sunday) are returned the following business day. However, if you have a mental health emergency, your options are as follows:

In case of emergencies:

- Call 911
- Go to your nearest emergency room or have someone drive you to the emergency room
- Behavioral Link (SPOE) – (800) 715-4225 for Mobile Crisis Unit
- Suicide Hotline (800) 273-TALK

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Seeking admission:

- Call Ridgeview Institute at (770) 434-4567
- Call Peachford Hospital at (770) 454-5589
- Call Grady Emergency and Crisis Center (404) 616-4444

Professional Boundaries

Psychotherapy is a professional service we provide to you. Therefore, the therapist-patient relationship is of a professional nature only. Please understand that your therapist will be unable to accept money from patients or loan money to patients. Accept gifts, socialize, become friends, conduct business transactions (including Girl Scout cookies, Mary Kay, etc.) or accept food/pastries from patients. Attend Church, hire patients, be romantically involved or sexually intimate with patients. Patronize your place of business, provide references, or participate in tactics to deceive a friend or love one into coming to therapy. Accept invitations to events, join multi-level marketing pyramids, accept rides, or transport patients. Discuss political views, religion, or self disclose personal matters. Record or take pictures without permission, or accept friend request on Facebook.

It is our ethical and professional obligation to maintain a professional role. Please note that these guidelines are not meant to be discourteous or impersonal in any way. They are for your protection. In addition to the above, it is usual and customary to ask permission prior to appropriate touching such as hugs, pat on the back, playful hitting, or gestures. Routine handshakes are appropriate when initiated by the patient. Please be mindful that colognes and perfumes can be distracting and that some are allergenic and intolerable to others.

Risks and Benefits of Therapy

Just as there are moments of discomfort when receiving a massage, there may also be moments of discomfort in therapy as well. It is during these moments that some patients leave therapy prematurely. Secondly, as you adjust to new behaviors and thought processes, others around you react in various ways. For example, some may have to get use to you being more assertive. Further, feeling good or bad after therapy is common, and both are part of the therapeutic process. In addition, the information provided to insurance companies might impact you in a variety of ways should you have a need to disclose information to a third parties such as in the case of security clearances, employment, your significant other, personal injury cases, lawsuits, etc. You may refuse treatment at any time during your therapy process. However, refusal of treatment poses a risk for both patient and therapist. Your therapist will discuss potential risks and ramifications involved with refusal of treatment. Your therapist may request a signed statement of your refusal to be treated.

Techniques, Therapies, and Terminations

Therapies: Therapies within our scope of practice include: Cognitive Behavioral Therapy (CBT); Motivational Interviewing (MI); Motivational Enhancement Therapy (MET); Psychodynamic Therapy; Transactional Analysis (TA); Solution Focused Therapy; Play Therapy; Object Relations; Spirituality; Therapy supplements include 12 step groups, self-help groups, collective wisdom groups, essential oils, etc.

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Techniques: Techniques include: as role-plays, take away assignments, didactics, visual exercise, music, videos, workbooks, imagery, & journaling to enhance the therapeutic experience.

Terminations: The length of therapy is a collaborative decision between you and your therapist. However, you may end therapy at any point. We recommend proper closure when terminating therapy. This procedure may take up to 3 sessions. Your therapist may also terminate the therapy process for various reasons such as when a patient may need a higher level of care or a referral due an issue beyond the scope of our practice.

In the event your therapist becomes incapacitated or expires, a designated colleague will contact you to discuss plans for the continuation of your therapy and provide further instructions to you regarding the transferring of your health records. Of course, you have the option of selecting and continuing your therapy with any therapist of your choice.

We sincerely look forward to being a part of your journey of liberation, empowerment, and transformation. If you have any questions about any part of this document, feel free to consult with your therapist.

Please provide your signature and date below to indicate that you have read, understood, and give your consent to proceed with treatment with the full understanding of the risks, benefits and expectations involved.

Patient_____ _____ Date_____

You attest you are mentally competent to sign this document

If applicable:
Parent/Legal Guardian_____ Date_____

(in case of minor under age 18)

Therapist/Credentials_____ Date_____

Therapist signature indicates contents were discussed and questions were addressed prior to treatment