Center for Psychological Discovery

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CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES;
CONFIDENTIALITY STATEMENT; PAYMENT AGREEMENT

Minor Client Form - Child's name:_____

I, _____, understand that psychotherapy and psychological testing have both potential risks as well as potential benefits. I understand that the risks may include, for example, uncomfortable levels of unpleasant emotions. It is also possible that individuals receiving therapy may feel worse, emotionally, before they begin to feel better due to the exploring of uncomfortable experiences and topics.

I understand that all information disclosed by me in therapy or during testing is maintained in strict confidence and that documents pertaining to my treatment will not be released to others parties except when mandated by law. I understand that if the therapist has reason to believe that a child or elderly person has been abused or neglected, then the therapist is legally required to file a report with the appropriate authorities. I understand that if I express serious intent to physically harm myself or another person, then a report to appropriate individuals will be required.

It is my expectation that I will be made aware of my child's progress in non-specific terms, but that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

Limits to Confidentiality – All communications between therapist and client is held in strictest confidence unless:

- The client (or legal guardian) authorizes release of information with a signature and waives this privilege.
- The therapist is ordered by a court to release information (not a subpoena but a court order from a judge)
- Dependent or elder abuse and/or neglect is suspected or revealed.
- The client appears to pose a direct threat to themselves, or someone else's life (ex. Actively suicidal or homicidal).
- Patriot Act-in certain circumstances, the therapist may be required to provide records upon request to the FBI.
- Insurance verification for medical necessity determination.

Divorce and Custody – I understand that this provider is not a custody evaluator and cannot make any recommendations on custody. She can refer me to a list of licensed psychologists who provide custody evaluation if needed. She requires a copy of the current, standing court order showing custodial rights for each parent and/or the parenting agreement that is signed by both

parents and the judge at the first intake session before she is able to meet with my child. I understand that she will need to have contact with the parent who has legal custodial decision making for medical issues before she sees my child for evaluation or treatment and will need to obtain written consent for the child to participate in counseling from the legal custodian, and prefers to have contact with both parents prior to seeing my child.

Legal Proceedings – I understand that I am being asked to waive the right for this provider to be summoned by subpoena to court. The policy is set in order that this provider can preserve the efficacy and integrity of my therapeutic process and my relationship with me and my child(ren). This provider's appearance in court can damage the therapist-client relationship and it is her ethical duty to make every reasonable effort to promote the welfare, autonomy, and best interests of her clients. By signing this agreement, I am waiving my right to have this provider subpoenaed and agreeing to not to have her or her records subpoenaed.

Court Testimony – I further understand that there may be other conditions (such as a court order) that may place limits on the therapist's legal ability to maintain my confidentiality. Due to the fact that the therapeutic process often involves disclosure of many matters which are confidential in nature, it is agreed that should there be any legal proceedings neither myself, nor my attorney, nor anyone else acting on my behalf will call on this provider to testify in court or at any other proceeding, nor will a disclosure of therapy records be requested.

- If this provider is required to testify for court, speak with legal counsel, prepare documentation, etc. the fee is $300.00 an hour plus mileage and expenses incurred. This provider will not testify in divorce custody or mediation. A two hour minimum will be charged.

Fees, Charges and Responsibility for Payment – I understand that payment, in the form of cash, check, or credit card, is due after each session. Individual sessions are 45-60 minutes in length depending on whether the session is being billed to insurance or not. Fees are as follows:
Psychological evaluations are $250 per hour billed/or negotiated rate:_____.
Psychotherapy is billed at $150 per hour/or negotiated rate:_____.
Forms, letters, and affidavits will incur a $25 per report fee/or negotiated rate:_____.
A fee of $25 will be incurred should my check be returned.
I will also be responsible for any expenses incurred to collect unresolved balances as well as a 25% additional fee, and I understand that I may waive my right to confidentiality in the event that the unresolved balance is sent to a collections company or agent.

Appointments – Sessions are scheduled directly with my therapist. I am required to give at least a 24 hour notice to my therapist in advance if I am unable to keep a scheduled appointment, to prevent being billed for the session. I can reach my therapist at 678-820-8386 and leave a voicemail. **I will be responsible for the session fee, if less than 24 hours' notice is given**. Please note that insurance companies do not reimburse for missed sessions. I understand that, unless otherwise indicated, insurance claims will not be filed on my behalf, but that I will receive an invoice to send to my insurance company. Unless alternative payment arrangements have been made prior to the delivery of services, I understand that payment is due at the time services are delivered. I understand that psychological testing reports will not be released until payment for the evaluation is made in full. I understand that I will be charged full psychotherapy or

psychological testing fees and I agree to pay those fees in the event that I fail to show for an appointment or cancel an appointment with less than twenty-four hours notice. Repeated late cancellations or failure to show for scheduled appointments may result in my termination as a client.

Use of Technology – Individuals may contact their therapist using technological resources. In doing so, they agree to the understanding that cell phone, text, email and fax communication are not guaranteed confidential methods of communication. When used, the client is by choice, relinquishing their rights to confidentiality. If I send an email to my therapist, she will review my email prior to the next session. Texting is allowed for scheduling or rescheduling appointments; but no clinical dialogue will be shared via text. You may text at 678-820-8386. I understand that, although I may engage in the use of social media, this provider is not permitted to friend, follow, or message me via social media outlets due to the nature of her ethics code (APA 2010).

In Case of Emergency – I understand that this provider does not provide emergency services. She will make every reasonable effort to return my calls as soon as possible and at least within 48 hours of messages being left during regular business hours. I will receive a card from my provider with all of the ways for contacting her. If I have a mental health emergency, I am encouraged to do one of the following:

- Call 911
- Go to your nearest emergency room
- Fulton County Suicide Hotline Number – 404-730-1600
- Forsyth County Suicide Hotline number – 770-781-6841

Consent – My signature below indicates that I have read, been advised of, and understand the above information and that I consent to receive psychological services under these conditions. I also acknowledge that I have read and understand the HIPAA Georgia Notice Form.

Signature of Client: _____Date: _____

Signature of Legal Guardian/Parent: _____Date: _____