

Brittanni Young, LMFT, CST
Licensed Marriage and Family Therapist
Johns Creek & Alpharetta Counseling for Children and Adults
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Information for Clients and Informed Consent

The following information is designed to provide you with both general and specific information regarding counseling services, as well as to gather relevant and important information from you. Please read carefully through this information and let me know what questions or concerns you may have. Thank you and I look forward to working with you!

About your therapist...

I am a Licensed Marriage and Family Therapist in the state of Georgia. I have a Masters degree in Marriage and Family Therapy with rich experience providing psychotherapy services for individuals, couples, and families. I am trained as a Gottman Level 2 Couples therapist and trained as a Trauma-Focused Cognitive Behavioral Therapist. Also, I am a Board Certified Sex Therapist and Clinical Sexologist with the Therapist Certification Association.

Office Hours:

Monday 11AM-7PM. Tuesday 4 PM-7 PM. Wednesday 11 AM- 7 PM & Friday 11 AM-5 PM.

My last session starts at 7 pm after work & school convenience. I do answer and return phone calls when I am out of the office. However, I wait until I am a private setting out of respect for your confidentiality.

Theoretical Views & Client Participation...

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that

you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or I don't hear from you for one month, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming treatment is always an option.

Benefits and Risks of Counseling....

Benefits of counseling have been shown in many well-researched studies. People who are depressed often find their mood lifting. Anxieties preventing normal functioning can be mastered. Therapy can allow people to work through what is bothering them until their feelings are naturally resolved. Skills in relationships and communication often greatly improve. Counseling may help clients to develop and maintain a sense of balance in life followed by more lasting contentment, satisfaction and skills for coping with inevitable challenges life presents.

Risks of counseling include feeling uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding way to balance. It is not uncommon (especially with children) for symptoms to worsen before improving. Clients may recall unpleasant memories. Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed. It takes great courage to begin the process of counseling. If you have any questions about what to expect in your journey through counseling with me, I am more than happy to discuss this with you not only in our first session together but throughout the process.

Confidentiality....

It is a client's legal right that our sessions and my records about you are kept private. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are exceptions as follows:

1. If you make a serious threat to harm yourself or another person.
2. If you give me reason to believe a child or any adult dependent has been or will be abused or neglected, I am legally required to report this to the proper authorities.
3. If you are or will be involved in court proceedings and my records and/or my testimony is subpoenaed and ordered by a judge.
4. If a guardian ad litem (GAL) is appointed by a court in a custody case involving your child as my client and the court gives the GAL access to mental health records.
5. The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

6. I am happy to provide paperwork for you to file with your *insurance company* or file for you when I am in your network; however, in doing so, there will be a diagnosis required and there may be a violation of your confidentiality as insurance companies do not always observe the same strict confidentiality guidelines that I do as a Licensed Marriage and Family Therapist.

7. My professional supervision and/or consultation with other licensed therapist are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality so that any information shared does not leave the room in which it is shared and full names are not revealed.

8. If you should choose to communicate with me via email I cannot guarantee your confidentiality as sometimes an email remains on a server and may be accessible by others. My email address is *Brittanni@BYoungTherapy.com*. If you plan to communicate via email please limit it to scheduling and cancelling appointments, and reframe from revealing details about yourself, as I will do the same.

Yes, I understand my email is a limit to confidentiality and I do authorize you to communicate with me via email: _____ (signature)

9. In the case of my death or major medical incapacitation, all of my records will be accessed by Erica Gregory, LPC, Owner and Director of Alpharetta & Johns Creek Counseling. You will be contacted by her on my behalf.

More on Confidentiality:

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations. I also will report any information associated with imminent danger of the child, therefore allowing the parents to protect their child.

In **working with couples and families**, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. ***I will not be a "secret keeper" nor will I facilitate secret keeping.*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it or I may have to terminate the therapeutic relationship and refer you to another therapist.

I understand the risks and benefits of counseling, and I understand my privacy and confidentiality rights.

Printed Name _____ **Signature** _____ **Date** _____

Printed Name _____ **Signature** _____ **Date** _____

Divorce and Custody....

*****I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.*****

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

1. I require a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session BEFORE I am able to meet

you child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

2. I will be available to provide an interview with a guardian ad litem (GAL) assigned to investigate the best interest of any child I am counseling upon production of court order demonstrating the GAL's right to examine your clinical record or speak with me. Otherwise, the adult client or parents of child client will need to sign a release for me to speak with the GAL. The client will be charged a full session fee for me to have such meeting with a GAL.

3. I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

4. Family sessions will likely be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

5. **I ask all my clients waive right to subpoena me to court.** This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child(ren). It is my experience that my appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

6. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of \$125/hour of my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at \$120 per hour.

I understand these policies and hereby waive any and all rights to subpoena Brittanni Young, LMFT, CST and her clinical record on any current or future legal proceedings.

Printed Name _____ Signature _____ Date _____

Printed Name _____ Signature _____ Date _____

TeleMental Health Statement

TeleMental Health is defined as follows:

“TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health

facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers.” (Georgia Code 135-11-.01

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Even though we will only utilize texting for appointments, I utilize a special messaging software within my Therapy Appointments portal for your added protection. I have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and the company has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. I encourage you to also utilize this software if you do not wish for others to have access to our communications. I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., password protected).

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. Sometimes I will submit out of office documents via attachment through email. If you would like to opt-out of this means of transmission for document submission than initial here: _____.

You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Video Conferencing (VC):

Video Conferencing is an option for your therapist to conduct remote sessions with you over the internet where you may speak to one another as well as see one another on a screen. We utilize Doxy.me This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.me is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your therapist choose to utilize this technology, your therapist will give you detailed directions regarding how to log-in securely. We also ask that you please sign on to the platform at least five minutes prior to your session time to ensure you and your therapist get started promptly. Additionally, you are responsible for initiating the connection with your therapist at the time of your appointment.

We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

However, I have a **professional** Facebook page and **professional** Twitter account. You are welcome to "follow" me on any of these **professional** pages where I post therapeutic content and practice updates. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Johns Creek and Alpharetta Counseling Center for Adults and Children and/or Brittanni Young, LMFT, CST, P.C. Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Blogs:

I may post therapeutic content on my professional blog through my website. If you have an interest in following my blog, please feel free to do so. However, please be mindful that the general public may see that you're following my blog. Once again, maintaining your confidentiality is a priority.

Website Portal:

I have a client portal that is accessible through my website at www.byoungtherapy.com or www.schedule.care, which is powered by Therapy Appointments. Therapy Appointments ensures this portal is encrypted to the federal standard, HIPAA compatible, and has agreed to sign a HIPAA Business Associate Agreement (BAA). The BAA means that Therapy Appointments is willing to attest to HIPAA compliance and assumes responsibility for keeping our interactions secure and your PHI confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also strongly suggest that you only communicate through a device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). Additionally, through the client portal, you have the option of receiving text and/or email reminders of your appointments with me and/or billing information. If you would like this service, please check the "Website Portal" option at the end of the document.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Billing Purposes

If I am credentialed with and a provider for your insurance, please know that I utilize a billing service who has access to your PHI. Your PHI will be securely transferred electronically to Office Ally, LLC. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions:

I utilize Cayan in Alpharetta and Square in Marietta as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Brittanni Young LMFT, CST, LLC or JCAC.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or

have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

- € Texting
- € Email
- € Website Portal

- € Video Conferencing
- € Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Scheduling and Cancellations:

I require **24 hours notice of cancellation** of any appointment. **If a client does not arrive for a scheduled appointment or cancels inside of 24 hours you will be charged for the session.** On the most rare occasion there is what I consider to be a *true, absolute, unavoidable emergency* I will waive the charge.

If you or your child are contagious please call me as soon as you notice these indications as we do not wish to put other clients at risk of illness. I simply ask for 24 hours notice whenever possible. If sudden onset, call me as soon as possible and request waiver of the 24 hr. notice policy.

Session Parameters...

Individual, couples counseling sessions and family sessions are **50 minutes**. Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance...

All fees are paid directly to Alpharetta Counseling. Alpharetta Counseling does accept Master Card, Visa and Discover, and American Express.

I am happy to provide paperwork for you to file with your insurance company for out of network reimbursement. I cannot guarantee your insurance company will reimburse for my services. I provide summary super-bills aka receipts and the end of each month for each appointment that occurred that month.

It is up to you as the consumer to connect and stay abreast with your insurance policy coverage in regards to services rendered. It is encouraged to inquire about deductibles, co-payments, co-insurance and prior authorizations necessary for coverage and fulfillment of financial obligation to services rendered. In the case of denied claim, you as the consumer of the policy have 30 days from notification of denial to communicate and act on necessary efforts for approval before full financial responsibility passes to you. The card on file will then be charged for owed amount.

Please initial in indication of understanding: _____.

Reduced Fees are available with application and are extended based on financial need. Please ask me about reduced fee options. I am sensitive to current economic challenges and will be more than happy to discuss alternative payment agreements at our initial intake session. A reduced fee agreement will be signed once application is approved.

There is a **\$25 fee for any returned checks.** That \$25 fee is due at the time of your next session, along with the payment for that session. If I receive two (2) returned checks from you, I will require that you pay using cash or credit card only from that point on.

Standard Fees:

- Couples and Specialty Services: Initial Intake Session \$200 and all Ongoing Sessions thereafter \$145
- Preparation of Summaries of Treatment or Letters at request of client: \$75 per item requested.
- Court Related and/or Child Specialist Work for Collaborative Law Cases: \$145/hour of any and all time spent on the case.

It is best that payment of fees be made at the beginning of each session or placed in my envelope before session so the business can be out of the way and you and/or your child can have needs addressed and focus on the issue at hand for the remaining session time.

After Hour Support and Emergencies...

Alpharetta & Johns Creek Counseling for Children & Adults is not an emergency services agency. I do not provide emergency services. If you have a life threatening or mental health emergency please call 911. After you call 911 you may call me at 770-971-9311 ext. 8 and leave me a confidential voicemail including your phone number even if you know that I have it along with a brief message. I will call you back when I have finished all sessions and business with other clients or between sessions if possible and if not possible the same day that you leave the message, as soon as I can the next business day. When I am away from the office for extended time, my outgoing voicemail message will reflect when I will be back. I also provide all clients in advance my away-from-office dates.

Other after hour Mental Health Resources (not to be substituted for calling 911 with emergency):

Ridgeview Institute at 770.242.4567

Peachford Hospital at 770.454.5589

Cobb Mental Health Crisis Line 770.422.0202

Fulton Mental Health Crisis Line 404.730.1600

My Records...

You should be aware that, pursuant to HIPAA, I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of \$135 charged for copying and mailing the record for release.

Client Rights...

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

Complaints or Grievances...

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number:

**Georgia Composite Board of Professional Counselors,
Social Workers, and Marriage and Family Therapists**
237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

Initial Interview, Assessment, and Possible Referral

The first appointment is an assessment interview in which your needs and expectations are discussed and a preliminary determination is made as to what services would be most beneficial to you. On occasion, this may require more than one interview. If the services provided by Brittanni Young do not meet your needs, she will refer you to a more appropriate resource. Full payment is expected at the time of this service.

Notice of Privacy Practices – Short Version

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law to do this and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems.

I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for services, or for other business activities, which are called in the law “healthcare operations”. After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat you or your child.

Weekly Reserved Appointment Times:

I have begun to offer reserved time slots for appointments. This means you can designate the most convenient time of week for your appointment and make that “your slot.” I will not schedule anyone else during that time unless you let me know that you cannot come to that appointment. There are a few parameters to reserving your own slot.

1. By reserving a slot you have made an appointment weekly until you designate otherwise or cancel your appointment within 24 hours. The missed appointment fee will apply if you miss that appointment without proper notice.
2. If you miss two appointments within 4 weeks you will lose the reserved time. This does not mean you cannot come at that time in the future, it only means that the slot reverts back to a first come first serve bases for scheduling.
3. Reserved slots are weekly only

Our Agreement To Enter into Counseling Services

I have read or had read to me all the information in this above paperwork pages 1 - 5, have initialed the bottom of each page of this agreement indicating that I have read them and understand them, have had a chance to review and ask questions and have had all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received the HIPAA notice form mentioned herein.

Printed Name _____ **Signature** _____ **Date** _____

Printed Name _____ **Signature** _____ **Date** _____

Client Information:

Name of Client(s)

1) _____ Date of Birth ___/___/____ Age _____ Occupation _____

Home phone _____ Cell phone _____ Approval to leave voicemail _____

2) _____ Date of Birth ___/___/____ Age _____ Occupation _____

Home phone _____ Cell phone _____ Approval to leave voicemail _____

3) _____ Date of Birth ___/___/____ Age _____ Grade Level _____

4) _____ Date of Birth ___/___/____ Age _____ Grade Level _____

5) _____ Date of Birth ___/___/____ Age _____ Grade Level _____

Parent/Custodian if client is child, _____

If divorced or not natural parent, please bring custody documentation to your first appointment.

Person in case of emergency you authorize me to contact (name, relationship and number)

How did you hear about me and my services? _____

Email Address _____

Mailing address _____

Appointment reminders: You can opt to receive appointment reminders the day before your appointment. Appointment information is consider "Protected Health Information" under HIPAA. In signing below, I am waiving my right to keep this information completely private, and requested that reminders be handled as noted below.

Text reminders are a convenience, not a requirement. If you do not receive a reminder you are still responsible for making the appointment as scheduled.

___ use cell phones listed above

Use the following number (limit 2) _____, _____

If you use texting or email to change an appointment, the new appointment is not official until I respond with "I now have you down at..." This insures that I received the message and the slot is still open for you. If you do not receive a response within 4 business hours, please call to verify that I received the message.

Fees for Services Agreement

Every time I schedule an appointment with my therapist at ACCA I understand that I am entering into a contract with Alpharetta & Johns Creek Counseling for Children & Adults (ACCA) and for the professional time and services provided for that appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and confidential consultations with other professionals. I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agree that my fee for sessions will be \$_____ and I agree to pay this fee at the beginning of my session. I understand that ACCA does not reimburse for canceled appointments that were paid for in advance but that any such fees will be credited to your account and applied to future services provided. I understand that ACCA's cancellation policy requires 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session.

I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged a full session fee for the appointment. I hereby authorize ACCA to charge my Visa/ Master Card/ Discover/American Express if I indeed fail to observe this cancellation policy.

I also understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with Brittanni directly and request a waiver of this policy but I understand that Brittanni is not bound to grant that waiver and may by this contract proceed with charging my credit card as agreed herein.

Signature of Authorized user of the card _____, Date _____

Therapist signature and date _____