4485 Tench Road, Suite 1220 A
Suwanee, GA 30024
www.authentic-life.net

Information, Authorization and Consent for Treatment

Welcome to Better Mental Wellness. I am very pleased that you have selected me to be your therapist and look 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. I welcome any questions, comments, or suggestions regarding your course of therapy at any time. My greatest desire is that our time together promotes your peace, joy and best-self.

Statement Regarding Ethics and Client Welfare

My professional license allows me to practice only within specific areas of mental health. For example, I cannot write prescriptions, nor proctor many aspects of psychological testing. My primary responsibility is to my clients. I will make every effort to promote the welfare of my clients and serve towards their best interests and that of their families. I will provide services consistent with that of the ethical standards set by Georgia Licensure Board (Composite Board) Code of Ethics, American Mental Health Counselors Association (AMHCA) Code of Ethics, and American Counselors Association (ACA) Code of Ethics.

If you for any reason are not satisfied with the services that I provide, please let me know. If no resolution is reached, I will provide you with contact information to the licensing board that oversees my profession.

Background Information

Providing information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask. You can also visit www.authentic-life.net. Validation of my license is available at http://sos.ga.gov/index.php/licensing

Theoretical Views & Client Participation

Because of the nature of individual issues, client expectations, and planned goals, it may be necessary to have a few sessions with a client while others may need more. Each client is an individual and a cookie cutter treatment modality is not realistic. As you enter therapy, commitment to self-awareness and honesty is vital to a positive therapeutic outcome. My approach is client centered and the expectation is that the client take an active role and can with my assistance resolve their own problems. Therapy is not advice giving. Self-awareness promotes an atmosphere of growth, empowerment, and transformation. In the event, additional support is needed, I will provide resources to assist you in your journey to emotional wellness, growth, and balance.

Confidentiality and Record Keeping

During our work together aspects of our communication will become a part of a clinical record of treatment called the Protected Health and Information (PHI). Some of the information contained in a PHI record may include clinical interventions, diagnostic impressions, client's behaviors, mood and cognitions, motivation, tracking of progress, and barriers to change. Please be aware that this is not an exclusive list and I may record more specific information of your circumstances in order to keep track of your progress. Your PHI will be kept on a password protected computer in an encrypted file format.

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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 unusual 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 counseling, **I do not agree to keep secrets**. Information revealed in any context may be discussed with either partner.

Finally, to further protect your identity, if we were to run in to each other somewhere in the community, I will not acknowledge you unless you speak to me first.

Emergencies

Because of the nature of my practice I am not equipped to provide 24 hour responses to emergencies. I can only treat individuals who are reasonably safe and stable. I do not carry a beeper nor am I able to immediately respond to phone calls. However, I do try to return calls within a 24 hour time period. 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. If you have an emergency which requires immediate attention I encourage you to call the following:

1. **Laurel Wood at 844-221-2276**
2. **Summit Ridge at 678-442-5800**
3. **Ridgeview Institute 770-434-4567**
4. **Peachford Hospital 770-454-5589**
5. **Call 911**
6. **Go to the Local Emergency Room**

Structure and Cost of Session

During the first session we will explore the nature of the problem and the unique circumstances which resulted in you (or your family) seeking therapy. We will discuss in depth the nature of your problem such as intensity, duration, coping skills. Therefore please allow up to 1.5 hours for the first session.

First sessions are billed at $140 for 1.5 hours.
Follow up sessions are 1 hour and are billed at a rate of $95.

Doing psychotherapy by telephone is not ideal, and needing to talk frequently 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. Telephone calls that exceed 10 minutes in duration will be billed at $1.50 per minute. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express, and Flexible Spending Accounts are acceptable for payment, and a

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receipt of payment can be provided if you would like one. Please note that there is a $30 fee for any returned checks. If there is a lack of payment, I reserve the right to contact a collection agency

I do not accept any insurance. However, I am a non-participating member for some insurance panels which means you may be reimbursed at the out of network coverage provided by your plan.

Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. **Be advised that if you use your insurance benefits to pay for psychotherapy, a mental health diagnosis is included, which will become part of your permanent health record.** The cost of each session is therefore your sole financial responsibility, and I will not intervene with insurance companies to collect reimbursement.
Any paperwork, beyond receipts, including reading documents, writing correspondence or copying of files will be billed at a rate of 45$ per 30 minutes, with a 45$ minimum.

Cancellation Policy

Cancelling and rescheduling appointments have a big impact from both a financial and personal standpoint. Both frequent cancellations and frequent rescheduling will be discussed if either are recurrent, and may result in termination.

Cancellations are expected to be **for emergency circumstances only**. Authentic Life Counseling requires 48 hour prior notification for all cancellations. If this advanced notice is not received you will be responsible for paying a 50$ cancellation fee. Rescheduling cancelled appointments will be made as soon as an opening is available that suits both of our schedules. Please note, if you are filling our sessions with your insurance company, you will be not reimbursed for missed appointments.

Court Appearances, Subpoenas and Other Paperwork

Tracy Gainer will not appear in court or provide written statements on behalf of any client.

In order for counseling to be truly effective and beneficial to the client it must be conducted and preserved in an atmosphere of honesty, self-reflection, openness and comfort for the client and their counselor. When there is a threat of court interaction (subpoenas, and/or summons for separation, divorce, custody, legal actions, disability claims etc.) this therapeutic relationship is compromised. By signing this statement, you are waiving all rights to subpoena or to use Tracy Gainer, Better Mental Wellness in any current and/or future court litigations or actions. **If a client files a complaint or lawsuit against Tracy Gainer or Better Mental Wellness we may disclose relevant information regarding that client in order to defend ourselves.**

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record. If I believe it necessary to subpoena my therapist, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half

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(1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, our relationship 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 way, we 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.

You should also know that therapists are required to keep the identity of their clients confidential. For your confidentiality, I will not address you in public unless you speak to me first. I must also 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 ethical duty as a therapist 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.

Our Agreement to Enter into a Therapeutic Relationship

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.
Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you.

_____

Client Name (Please Print) Date

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Client Signature (Please Sign) Date

If Applicable:

_____

Parent or Legal Guardian's Name (Please Sign) Date

_____

Parent or Legal Guardian's Signature (Please Print) Date

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