4485 Tench Road, Suite 1220
Suwanee, GA 30024

Information, Authorization and Consent for Treatment

Welcome to Authentic-Life Counseling. 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. Providing this document is part of an ethical obligation, and 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. The work we will be doing falls under the broad spectrum of counseling or psychotherapy. My services will be rendered in a professional manner consistent with the ethical standards of the National Association of Social Workers. If at any time you feel that I am not performing in an ethical or professional manner, please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Psychotherapy has both benefits and risks. Research indicates that two-thirds to three-quarters of clients find therapy to be helpful. Psychotherapy often leads to a significant reduction of distress, improved relationships, and the resolution of specific problems. However, since psychotherapy is not an exact science, there are no guarantees about what you will experience.

The risk of psychotherapy includes feelings of frustration, fear, anger, and sadness. You may have to talk about things that are difficult to discuss. Your therapy may also involve recalling unpleasant aspects of your history or having new insights into yourself and others that may feel uncomfortable. Psychotherapy will also probably involve making changes in habitual thinking, emoting or cognitive patterns. These changes are not easy

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. Validation of my license is available at http://sos.ga.gov/index.php/licensing.

Theoretical Views & Client Participation

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.

While it is difficult to determine the number of sessions that will be needed to reach your goals, in general, the phases of therapy are as follows:

Starting Phase	3-4 Sessions	Weekly
Working Phase	4-12 Sessions	Weekly, then biweekly
Ending Phase	2-6 Sessions	Monthly
Follow-up Phase	2-4 Sessions	Semi-annually

These are suggestions not requirements, and you are able to cancel your treatment at any time. However, if you are

choosing to cancel because you feel your therapy is not going in the direction that you envision, please bring this to my attention. It is my intention to empower you in your growth process to the degree that you can face 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. If at any point you are unable to keep your appointments or I don't hear from you for one month, I will close your chart. Restarting therapy depends on availability and is therefore variable. .

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 to keep track of your progress. Your PHI will be kept on a password protected computer in an encrypted file format.

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) If a client of mine threatens to harm him/herself I may be required to seek hospitalization for that client, or contact family members or others who can help provide protection (3) If a client of mine is threatening serious bodily harm to another person, I may be required to take protective action, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization (4) You report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; I am required by law to file a report with the appropriate state agency: or (5) I am ordered by a judge to disclose information. In this 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. Also, for couples, in the event of a divorce, a request to release information to attorneys or any other adjunct professionals will require written release from **both** parties. During the history of my private practice, I have never seen both parties agree to sign a release.

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

Emergencies

The nature of my practice does not make it possible 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 24-hours. If 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

First sessions are billed at $150 for 55 minutes.
Follow up sessions are $125 for 55 minutes.

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 receipt of payment can be provided if you would like one. Please note that there is a $80 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 providing records of files will be billed at a rate of 75$ per 30 minutes, with a 75$ minimum.

Recording Sessions

Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapists(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith.

In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by the police, court or governmental agency. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters they may have been discussed. Courts may not give your own recordings all the legal confidentially they give to a therapist's office notes and may find them self-serving. Client records can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A client who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it.

For these reasons and others like them Authentic-Life Counseling maintains a strict policy on recording.
The client signing below agrees that:

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1. Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapist, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

2. Consent for each recording must take the form for dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all person's present, with such consent stated at the start of the recording or when they join a session or interaction already in process.

Authentic Life Counseling will only consent to recording of a session for exceptional reasons and only after the drawbacks and risks have been discussed and the benefit clearly outweighs them. Violation of this policy by overt recording or non-conformance with this agreement will lead to termination of therapy.

Cancellation Policy

Cancelling and frequent rescheduling of appointments have a substantial financial and personal cost that I am not able or willing to absorb. **Both frequent cancellations and frequent rescheduling 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 75$ 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

Diane Chrestman 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 Diane Chrestman, Authentic-Life Counseling in any current and/or future court litigations or actions. **If a client files a complaint or lawsuit against Diane Chrestman or Authentic-Life Counseling we may disclose relevant information regarding that client in order to defend ourselves.**

In the event that Diane Chrestman does become involved, a down payment of $1,500 is expected at the beginning of the related service. There will be a charge of $300 per hour of any work pertaining to court litigations/actions (paperwork, phone calls, appearances, etc.) This payment will be billed to the client and will be expected to be paid on a weekly basis: any statements left unpaid will automatically forfeit further interaction.

Professional Relationship

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

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.

<u>Our Agreement to Enter into a Therapeutic Relationship</u>

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(s) Name: (please include names of both partners if couples therapy)

_____ (please print name) Date: _____

_____ (please print name) Date: _____

Client(s) Signature: (please include signature of both partners if couples therapy)

_____ (signature) Date: _____

_____ (signature) Date: _____

If Applicable:

_____
Parent or Legal Guardian's Name if client is under 18 years old (Please Sign) Date: _____

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

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As part of my treatment, I have been informed and consent to the use of Energy Psychology.
This therapeutic approach uses the subtle energies and electromagnetic fields to address mental health issues. This treatment is a new approach of healing which falls under the broad category of mind/body connection.

I understand that the efficacy of this treatment has been collaborated in several scientific studies. Further, I understand that this treatment uses the aspects of healing which are still not fully understood by science.

I have been advised that there are currently no known side-effects to energy oriented treatments when properly administered by an experienced practitioner. However, as with any mental-health treatment, I am aware that sometimes addressing one aspect of mental-health issues uncovers more profound and deeper issues. Some examples of the types of deeper issues that maybe revealed includes, but is not limited to, repressed memories or unconscious beliefs.

I further understand that, because these methods are relatively new, the extent and breadth of their effectiveness, including risks and benefits, are not yet fully known. I have been advised of the following:

* Previously vivid or traumatic memories may fade. This could adversely impact the ability to provide detailed legal testimony regarding a traumatic incident.

* Reactions may surface during treatment that neither my therapist nor I can fully anticipate, including strong emotional or physical sensations, or additional, unresolved memories.

* Emotional material may continue to surface after a treatment session and give indication of other incidents that may need to be addressed.

* My therapist may refer me to practitioners who have specific skills to help with the problem areas that have been identified.

* Light touch may be involved in assessment with clinical kinesiology (muscle testing), for which I can choose to give permission or not.

* I will be learning how to perform personal self-care by working with my own energy system.

I have considered the above information before selecting to receive an energy therapy treatment and have obtained whatever additional information or professional advice I considered necessary to make an informed decision. I choose to participate in energy therapy of my own free will and know I have the right to cease using these approaches at any time. I agree to take full responsibility for my self-care in the physical, emotional, mental, and spiritual dimensions of my life.

My signature on this form acknowledges my choice to consent to the innovate approaches of energy therapy that my practitioner offers. My consent is free from pressure or influence from any person or group.

Client signature _____ Date _____