



Informed Consent

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.

Background Information

Providing information regarding my educational background and experience as a therapist is an ethical requirement of my profession. Validation of my license is available at <http://sos.ga.gov/index.php/licensing> while educational background can be found on my website www.authentic-life.net.

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	Between 1-3 Sessions	Weekly
Working Phase	Between 4-12 Sessions	Weekly, then biweekly
Ending Phase	Between 2-6 Sessions	Monthly
Follow-up Phase	Between 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.



Informed Consent

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. Georgia has a good track record in respecting this legal right. If for some unusual reason a judge orders 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.

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.

Additionally, since 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.

There is another dual relationship that therapists are ethically required to avoid. This is providing therapy while also providing a legal opinion. These are considered mutually exclusive unless you hire a therapist specifically for a legal opinion, which is considered "forensic" work and not therapy. My passion is not in forensic work but in providing you with the best therapeutic care possible. Therefore, by signing this document, you acknowledge that I will be providing therapy only and not forensic services. You also understand that this means I will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities. However, if for some reason I am compelled to testify to a court of law, I will require an upfront retainer of \$3,000.00, and my billing rate will be \$500.00 per hour plus you agree to be responsible for the reasonable attorney fees I am charged by my counsel. Additionally, if I receive a valid subpoena to produce or summarize any documents, I charge my prorated



Informed Consent

hourly rate for the time to produce this summary. I will also need to charge you the reasonable attorney fees associated with that production, which will take place by and through my counsel's office to preserve your confidentiality.

Statement Regarding Ethics and Client Welfare

I assure you that 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, I ask that you 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.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

For the safety of all my clients, their accompanying family members and children, and other staff in the building I maintain a zero tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. I reserve the right to contact law enforcement officials and/or terminate treatment with any client who violates my weapons policy.

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. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.



Informed Consent

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 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, 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. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. Therefore, **I do not utilize texting in my therapy practice.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. If you happen to send me a text message by accident, you 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. Text messaging may be used to set up appointments, but I prefer email.

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. 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.

Even though we will only utilize email for appointments and brief topics, I utilize a secure email platform that is hosted by GMail 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 also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If



Informed Consent

you are in a crisis, please do not communicate this to me via email because I may not see it in a timely manner. Instead, please see below under "Emergency Procedures."

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, Authentic-Life Counseling has a **professional** Facebook, LinkedIn, and Twitter account. You are welcome to "follow" me on any of these **professional** pages where I post therapeutic content. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Authentic Life Counseling. 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 psychology information/counseling information/therapeutic content on my website which includes a professional blog. 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 Authentic-Life Counseling. Once again, maintaining your confidentiality is a priority.

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize Google Meet Conferencing Platform. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Google Meet is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. **If we choose to utilize this technology, the link to join the conference can be found in your appointment reminder which is sent to your email.**

I 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.).

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 Certain Credit Card Transactions:

I utilize Square as the company to process 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 cardholder has the automatic receipt notification setup in order to maintain your confidentiality if you do



Informed Consent

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 Authentic-Life Counseling.

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 get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

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 may have some 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.

Identification & Passwords for New Clients

During our first session, I will require you to show a valid picture ID and another form of identity verification such as a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

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
- € 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.



Informed Consent

Communication Response Time

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. 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 are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you **not to wait for communication back from me**, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call or text 988 Suicide Prevention & Crisis Line
- Call 911.
- Go to the emergency room of your choice.

If we decide to include TeleMental Health as part of your treatment, there are additional procedures that we need to have in place specific to TeleMental health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name: _____ Phone: _____

- You agree to inform me of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

Hospital: _____ Phone: _____

Structure and Cost of Sessions

Based on your treatment needs, I may provide face-to-face, or video conferencing. The structure and cost of initial appointments for couples is \$195 per 90 minute session and \$160 for individual sessions.. Subsequent sessions are \$130 per 55 minute session for both couple and individual sessions.

The structure and cost of both in-person sessions and TeleMental Health is \$130 per 55 minute session. **Cash, personal checks, major credit cards, including Health Savings Accounts are acceptable for payment. You may choose to either pay in the office after the conclusion of the session, or receive an invoice which is sent to the email address you provide. Invoices received by email are expected to be paid the same day of service.**

Please note that there is a \$30 fee for any returned checks.



Informed Consent

Phone calls, texting, and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding and billed in 15 minute increments of \$32.50, with a minimum of 15 minutes.

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 usually required and 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.

Cancellation Policy

Cancellations are expected to be **for emergency circumstances only**. In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, please notify me 48 hours in advance. If such advance notice is not received, you will be financially responsible for a 75\$ cancellation fee.

Rescheduling canceled appointments will be made as soon as an opening is available that suits both of our schedules.

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, 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 confidentiality 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:

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



Informed Consent

recording or non-conformance with this agreement will lead to termination of therapy.

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.**

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(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: _____

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



Informed Consent

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 _____