SANDY SPRINGS PSYCHOLOGICAL ASSOCIATES

Informed Consent for Counseling Services

Welcome. Thank you for trusting us to assist you with your personal concerns. Please take the time to read and understand this document and ask your therapist about any part which may be unclear to you.

Services and Staff. I understand that Sandy Springs Psychological Associates is a professional agency offering counseling and assessment services including individual, couple and family counseling, consultation and psychological testing. All services are provided by a doctoral-level mental health professional.

Confidentiality. I understand that all information I disclose within sessions is confidential and may not be shared with anyone outside this office without my written permission. Limitations to this only apply in circumstances where disclosure is required by law, including:

1. If I present an imminent threat of harm to myself or to others.
2. When there is an indication of abuse of a child or dependent adult.
3. If I become gravely disabled.
4. By court subpoena.
5. Third party payers require certain information to reimburse, such as diagnosis. The law clearly specifies the limits of such information as to content and extent.
6. Any other exceptions to confidentiality must be expressly authorized by the client or parent/guardian.

In the case of clients under 18, parents and guardians are entitled to certain records and to consult the psychologist regarding treatment. In order for treatment to be most effective, we request that they respect the minor's wishes regarding privacy whenever possible.

Clients' Rights. In your first session, your therapist will offer you some sense of what therapy will entail and how he will work with you to address your concerns. At any time, you have the right to ask for the rationale of any aspect of treatment or to decline any part. You have the right to terminate treatment and request a referral to another therapist. We encourage you to discuss any concerns, but you are under no obligation to do so. You have the right to an explanation of what any psychological test(s) being administered are for, and you may decline at any time. You also have the right to a summary of any test results. *If you request a written report or letter, there will be a separate charge for this service.*

Risk and Benefits. I understand the possible of risks and benefits of participation in counseling. Risks may involve remembering unpleasant events and strong emotional responses. Counseling may also impact your significant relationships. The benefits can include an improved ability to relate with others; a clearer understanding of self, values, goals; increased academic or workplace productivity; and better ability to deal with stress. Participating in therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, these are not guarantees of what your personal experience will be.

Fees and Payment. Fees are $200 per hour for a diagnostic assessment and $175 thereafter unless previously arranged otherwise with Dr. Jenkins. Clients are responsible for the full payment of all fees at the time of service. We will provide a detailed receipt of payment for use in filing an insurance claim or for your records. As a courtesy, office staff can electronically file claims where allowed on your behalf; submitting claims is not a guarantee, and you should direct any questions about coverage to your insurance provider. If psychological testing is offered, you will be advised of the cost prior to testing. All testing must be paid for prior to. If you do not wish to be tested, you have the right to refuse. Other than a genuine emergency or illness, you will be billed for missed appointments unless you notify Dr. Jenkins or his office manager 24 hours in advance. The current fee scale is available upon request.

I offer primarily face-to-face therapy sessions. However, based on your treatment needs, I may provide phone or video conferencing (tele-mental health). The structure and cost of phone/video sessions and in-person sessions is the same. *I require a credit card ahead of time for appointments conducted via telephone or video for ease of billing; this credit card will be charged at the conclusion of your session, unless other arrangements are made in advance.* There is no charge for a brief call to "check-in" or coordinate scheduling; beyond that, phone calls are billed at my hourly rate.

Tele-mental Health Services: Please check the box next to the tele-mental health services you are authorizing this practice to use for treatment or administrative purposes. You may withdraw authorization at any time during your treatment by notifying us in writing.

- ☐ Text
- ☐ Email
- ☐ Video Conference
- ☐ Phone Calls

Emergencies/Crisis. Your safety is my primary concern. If you are unable to reach me or my office manager and you have a life-threatening emergency, immediately call 911 or go to a hospital emergency room. If your message is urgent, call my personal cell phone number at (678) 517 –1428 and leave a voicemail. I check my voicemail several times each day. I will return your call at my earliest opportunity.

Consent. Your signature below indicates that you have read and understood the information in this document and that you consent to evaluation and treatment under the provisions stated. If you do not understand or consent to anything stated in this document, it is your responsibility to request and receive clarification before signing.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

For Parents and Guardians of Minors. I attest that I have full legal authority to make treatment decisions for the minor named below and I give my permission for him/her to be evaluated and treated.

_____

Name of Client under 18 (PRINT)

_____ _____ _____

Name of Parent/Guardian (PRINT) Parent/Guardian Signature Date