Counseling Intern: __________________________

Consent to Record

I, ___________________________ (print name) give my consent to the above named Counseling Intern, at Ray of Hope Counseling Services, Inc. to audio/videotape my counseling sessions. I have been informed that all tape recording will be done with my full knowledge and will be used for counseling training, supervision, and/or consultation purposes only. Any other use of this material is unauthorized unless I give informed written consent.

The co-signature of the counselor on this form acknowledges full responsibility for the professional use and appropriate protection of and disposal of taped material. The third signature is verification by the Ray of Hope Counseling Services, Inc. clinical director that this consent form has been review and accepted by this agency.

____________________________________  Date: ______________________
(Signature of Client)

____________________________________  Date: ______________________
(Signature of Significant Other if Couple’s Counseling)

____________________________________  Date: ______________________
(Signature of Counselor)

____________________________________  Date: ______________________
(Signature of Supervisor)
FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For in and in consideration of services rendered and to be rendered to
_____________________________(client name), I will promise to pay Ray of Hope Counseling Services, Inc. I understand that the total charges are due when services are rendered.

I understand that I am financially responsible for missed appointments in which I do not give a 24-hour notice. Notice must be given via phone call. The fee for a missed visit in which less than 24-hour notice is not given is $37.00. This fee will be expected upon arrival of your next visit or charged to the credit card on file, before services are rendered.

If I do not pay the entire amount due to Ray of Hope Counseling Services, I hereby agree and give my permission to Ray of Hope Counseling Services to seek legal action to receive payment for services rendered. I also agree that in the event it is necessary to retain an attorney to enforce the terms of this agreement, relative to payment fees, Ray of Hope Counseling Services shall be entitled to reasonable attorney fees and cost of collection.

Please provide us with your credit card information. This card will ONLY be charged if less than 24-hour notice is given to cancel an appointment or on accounts which insurance did not pay.

Name as it appears on card: _______________________________________

Card #: _______________________________________________________

Expiration Date: __________________ CV Code: ____________________

By signing below, I am agreeing to the terms and conditions of this financial contract.

__________________________________  ______________________
(Signature of Client)               Date

__________________________________  ______________________
Witnessed                           Date
Intern Consent Form

Counseling Intern: __________________________

I, _____________________________ (print name) agree that my signature below indicates that I am aware that I am receiving counseling from a counselor that is in his/her internship program, in graduate school (master’s level). The internship is a work-related learning experience for individuals to gain experience in the counseling occupation. I have been informed that the intern is working under the supervision and direction of Lynn Thompson, LPC, and that she can be contacted at any time with concerns or questions in regards to the services rendered.

_____________________________       Date: __________________________
(Signature of Client)

_____________________________       Date: __________________________
(Signature of Significant Other if Couple’s Counseling)

_____________________________       Date: __________________________
(Signature of Counselor)
Informed Consent

Therapist: _______________________

Welcome, thank you for choosing Ray of Hope Counseling Services, Inc. This document is designed to answer some frequently asked questions about myself/the practice, the counseling process, our professional relationship, confidentiality, and your financial obligations. As you read this feel free to mark any places which are not clear to you or write in any questions which come to mind, so we can discuss them. Both of us need to be clear as to what your needs are and how I can best serve those needs. This will allow us to work most productively and comfortably together. If our work together uncovers a problem area beyond my expertise, I will help you obtain services from an appropriate specialist.

I am a graduate student and interning with Ray of Hope Counseling Services, Inc. to develop my counseling skills. I am supervised by two licensed supervisors: Lynn Thompson Umstead LPC, clinical director of Ray of Hope and a professor from my university. Any questions or concerns about my work can be addressed with Ms. Thompson Umstead at 678-213-2194.

This document (the agreement) also contains important information about my professional and business policies. You also have the right to obtain or review summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have given you the opportunity to review HIPPA regulations. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. The revocation will be binding on me except for obligations imposed on me by your health insurer in order to process and/or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

The therapists at Ray of Hope Counseling Services are trained and specialize in a wide variety of areas. The therapists at Ray of Hope Counseling Services are licensed by the state of Georgia and at a minimum have obtained a Master’s degree from a fully accredited school, or the therapist works under the direction of our clinical director. In addition, the therapists at Ray of Hope Counseling Services have a diverse background in training. Please feel free to ask your therapist any specific questions that pertain to their clinical background, approach, and training. You can also view each therapist’s profile at www.rhcounselingservices.com any time.

The ultimate goal of counseling is to gain self-awareness into what is disturbing you; explore and understand your thoughts, feelings, and behaviors; seek a greater sense of happiness and contentment; and for you to choose and maintain behavioral changes. To achieve these goals, some persons need only a few sessions, whereas others may require months or even years. Each therapy session will be fifty minutes in length, unless other arrangements are made.

I expect and encourage you to obtain knowledge of the procedures, goals and possible side effects of therapy. I will try to make our professional relationship one where you will receive the maximum benefits. I will also keep you informed about alternatives to counseling. Counseling may be tremendously beneficial for some individuals. At the same time, there are some risks. These may include the experience of intense and unwanted feelings including sadness, anger, fear, guilt, or anxiety. These feelings may be natural and normal and can be an important part of the counseling process. Other risks of therapy might include recalling unpleasant events, facing unpleasant thoughts/beliefs, increasing awareness of feelings, and or altering of your ability or desire to deal effectively with others in a relationship. In counseling, major life decisions are sometimes made. As your counselor, I will be available to discuss any of your assumptions, problems, or possible negative side effects of our work together. Although there may be negative side effects to counseling,
benefits of counseling have been scientifically demonstrated. Benefits might include the lifting of depression, fear, anxiety, or helplessness. You may be better able to cope with social or family relationships and find them more satisfying. You may better understand yourself, your goals, values, and grow and mature personally.

To achieve the ultimate goals of counseling, you need to have information and understanding of how counseling works. Counseling requires a large commitment of your time, energy, and money, so it is important that you are comfortable with me and open with me. However, if you are dissatisfied with me for any reason, I would greatly appreciate you discussing your feelings or thoughts with me. If at any time, you wish to consult with another therapist or get another opinion, I will help you find a suitable professional. Therapy is not like visiting a medical doctor, in that therapy requires your active involvement and efforts to change your thoughts, feelings, and behaviors. You will have to make an active effort both in our meetings and between our meetings. There are no instant, painless, or passive cures – “no magic pills.” Instead, there will be serious exploration of your history, feelings, thoughts, behaviors, and how you interact with others. There may be “homework” where you will have to think and feel, observe yourself and how you interact, and even complete assignments, exercises, keep diaries, or other projects. Change sometimes is easy and swift. However, for the most part, change is slow, frustrating, and requires hard work and dedication on your part. I will assist and help you with your struggles along the way.

I do not take on a client whom, in my professional opinion, I cannot help using the knowledge and techniques I have available. If I do not feel that I can be of help, I will refer you to others or agencies which would be better able to serve your needs. If necessary, I will make these referrals at our initial meeting. In some cases it takes multiple meetings to assess one’s needs or we may come to a point where I feel that I can no longer meet your needs. If that occurs, we will talk about the issues and I will direct you to the person or services, which will be better able to serve your needs.

**Contacting Me**

Due to my schedule, I am often not immediately available by phone. I am usually with clients. Therefore, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exceptions of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In emergencies, call 911 or go to the closest emergency room. If you are unable to reach me and feel that you can’t wait for me to return your call, contact your family physician or the closest emergency room and ask for the psychiatrist on call. If I will be unavailable for extended time, I will provide you with the name of a colleague to contact, if necessary.

Our administrative staff is in the office from 8am-8pm Monday through Friday to accept all calls. If you are calling after these hours to cancel or change an appointment you must leave a message on your therapist’s voicemail. It is office policy that we do not text or email with our clients, unless this has been discussed and agreed upon between the therapist and client.

**Confidentiality**

I regard the information and feelings you have expressed to me, with the greatest respect. In general, I will tell no one what you tell me. The privacy and confidentiality of our conversations and records are a privilege of yours and is legally protected by state law and my ethical principles. However, Insurance companies, but more likely, managed care companies (HMO, PPO, etc.) may ask for my progress notes for more detailed information on your symptoms, diagnosis, issue, my treatment plan, or methods. For managed care, after a certain number of visits or a designated amount of time, I have to submit a treatment plan. The treatment plan consists of all identifying information, diagnosis, treatment goals and approach, and other information. I will review these treatment plans with you at any time. However, after submitting a treatment plan or billing to a managed care company or insurance company I cannot guarantee this information will remain confidential, as
most insurance companies require us to electrically file the claim. Your name, diagnosis, and/or information/issues could be obtained by someone else. I try to enter on a treatment plan or claim form the minimum amount of information necessary. You will always have the choice of using or not using your insurance.

In addition, there are certain situations where what you say and who you are may be discussed or heard by another person. I may consult with another colleague regarding some aspect of your situation. I may at times talk with other persons, such as your physician, attorney, social service worker, or another mental health professional. However, if I need to speak with one of these professionals I will obtain a signed release of information form from you.

Secondly, upon occasion, I am away from the office. I have a trusted fellow therapist to “cover” for me at all times. He or she will be available for emergencies or anything urgent. If I feel that you may call while I am away, I will let him or her know in order to enable him or her to be better able to respond.

Thirdly, by law, I am required to report any evidence of child abuse or strong suspicions of child abuse or neglect. I am also mandated to report abuse of handicapped or elderly persons.

Fourth, if subpoenaed to provide information in a court of law, I will first assert client-therapist privilege, if it applies. However, I can be ordered by a judge to disclose that information.

Fifth, parents have the right to any and all information regarding their child. Because the presence of trust is important in the therapeutic relationship between your child and myself it is generally best that we do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your child’s treatment and the progress being made. If your child is able to understand the issues of confidentiality, I will discuss with him/her the type of information that will be shared with you. If you have any objections to the manner in which information is shared with you regarding your child we will need to resolve those differences before therapy begins.

Finally, if in my judgement, I feel any person is a serious and immediate risk of harming him/herself or another person, or will engage in criminal behavior, I will break confidentially. I will notify other family members, the person to whom harm is intended or the police in order to maintain safety.

To repeat, confidentiality will be maintained. It is only under the above situations that information will be imparted to others. Thus, you and your records have the privilege of privacy and confidentiality, but there are limits and boundaries. Please feel free to discuss your confidential exceptions with me at any time. This is particularly important from the onset of our meetings.

**Termination**

Termination is inevitable and it should not be done casually. Either of us may terminate our work together if we believe it is in your best interest. You can terminate at any time. I ask that we discuss the termination before we actually stop in order to review goals and accomplishments, and any future issues to resolve later. Finally, termination means we have met our goals, but we can always work together again in the future.

If I do not hear from you or have contact with you six weeks consecutively, then I will consider your case to be closed. However, the case can be re-opened at any time.

**Associates**

Please be advised that there are various persons who work in the same office as me. Knowing there are other people in the office that may become aware of you being a client, you agree to hold any other professional in the office as harmless and/or not liable for any legal or civil action.
Patient Rights
HIPPA provides you with several rights with regards to your clinical record and disclosure of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information in your clinical record is disclosed to others; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of the complete HIPPA Guidelines. I am happy to discuss any of these rights with you and/or provide you with a hardcopy per your request.

Billing and Payment
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another agreement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve sending your balance to our collection agency or going to small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client’s treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

Insurance Reimbursement
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Due to the rising cost of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care Plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Your signature allows me to submit a treatment plan to request further time or number of visits. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer.

Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share information with a national medical information databank. I will provide you with a copy if any treatment plan I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. However, it is important to
remember that you always have the right to pay for my services yourself to avoid the problems described above.

**Social Media**

In an effort to maintain and protect your confidentiality our practice does not engage with clients through social media. We will not accept your friend request on Facebook, follow you on Twitter, or communicate through Instagram, Snapchat, etc. Our practice only engages in social media from a professional platform, which gives no identifying information about our clients.

**Clinical Director**

Lynn Thompson Umstead, LPC is the clinical director of Ray of Hope Counseling Services and is available to address all clinical concerns or questions after you make every attempt to address your concerns with the treating clinician.

____________________________________  Date: ______________________

(Signature of Client)

____________________________________  Date: ______________________

(Signature of Significant Other if Couples’ Counseling)

____________________________________  Date: ______________________

(Signature of Counselor)