Restoration 23

3950 Cobb Pkwy Suite 604
Acworth, GA 30101

Informed Consent

We are pleased that you have sought counseling, and are committed to helping you identify and reach your therapeutic goals. It is vital for you, as client, to be fully informed about the therapy process. Your signature below indicates that you have received, read, and understand your rights and responsibilities under this agreement and consent to enter a therapy relationship with your counselor, based upon the terms of this agreement.

The Process of Counseling: It is our desire to provide a warm and trusting therapeutic relationship, wherein clients feel safe to examine patterns of behavior, thoughts, or emotions that are causing concern. Treatment goals will be established via ongoing collaboration between you and your therapist. Your counselor may help you explore possibilities and consequences of decisions, but his/her role is not to make decisions for you as a client. The purpose of counseling is to support, facilitate and empower your growth toward greater psychological health and satisfaction. While the process is effective for many people, there are no guarantees of success.

Please free to ask your therapist any questions you may have. The nature of your concerns will be discussed and recommendations made concerning treatment. If your counselor is not a good fit for your needs, as the counselor determines, appropriate referrals will be made and a second session will not be scheduled.

As Christian counselors, we believe that God loves us and is eager and available to help in our quest for personal and spiritual growth. *Only* upon your request, and to your comfort level, will we integrate Scripture and prayer in session. It is not necessary for therapeutic growth that you believe, express, or integrate spiritual views into therapy sessions or treatment goals. Each of our practitioners will operate from the highest level of respect and will regard your comfort level, personal and spiritual beliefs, and cultural diversity.

Services Offered and Clients Served: We offer a wide array of psychotherapeutic modalities in order to comprehensively treat individuals, couples, families, and groups. We provide services to adults, adolescents, and children.

Potential Counseling Risk: Participation in outpatient psychotherapy is strictly voluntary and can pose some risk. Therapy often involves experiencing a wide range of emotions, which may span a continuum of both positive and negative extremes. Due to the personal, pruning nature of the growth process, experiencing changes in your relationship with others may become a source of strain or difficulty for you during your therapy journey. Likewise, during the course of treatment, additional problems may surface which may shape or lengthen your treatment plan. Rest assured that our practitioners will continuously assess, relay, and collaborate with you on concerns and therapeutic goals.

Licensure: Our counselors are licensed by the State of Georgia, and are governed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. If your counselor is currently undergoing the process of licensure, she/he will be under the supervision of a Licensed Professional Counselor, as per the Composite Board requirements.

Judy Holley, MA, LPC	License # LPC006519
Joseph Trey Mickler, MA, LPC	License # LPC003204
Libby Watson, MA, LPC	License # LPC006514
Sarah Zipfel, MA, LAPC	License #APC006298

Code of conduct: As Licensed Professional Counselors and Licensed Associate Professional Counselors, we are required by state law to adhere to codes of conduct for practice that have been adopted by our licensing boards. We ask that a client contact his/her counselor if an ethical concern arises.

Confidentiality: Information shared by you in the counseling relationship is kept strictly confidential. We do not disclose client confidences and information to any third party, *except* under the following circumstances, and in accordance with state law: 1) The client signs a written release of information, indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, 3) There exists reasonable suspicion of abuse/neglect against a minor child, elderly person (60 years or older), or a dependent adult, or 4) A court order is received directing the disclosure of information. It is our policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. We will endeavor to apprise

clients of all mandated disclosures as conceivable.

Fees: Our counseling fee is $80.00 per 50 minute session. Most of our counselors do not accept insurance as payment, but your individual counselor may be able to accept certain insurance plans. Please let your counselor know if you have insurance you would like to use. Your counselor, at his/her discretion, may offer a sliding-fee scale based upon financial hardship. Please discuss any financial hardship you may have with your counselor upon intake. A standard session is 45 to 50-minutes in length. If additional time is needed/utilized, additional fees will be applied.

If your therapist is subpoenaed to testify or submit records to the court, a fee will be assessed. For a written report, a fee of $150.00 will be charged. Because appearing in court requires cancelling a full day of clients, you will be billed for a full day for each day the counselor is required to report. The fee for the full day is $1000.00. You will be billed $50.00/hour for preparation time. If the court appearance is more than 20 minutes away from the office at which you typically attend sessions, mileage will also be assessed.

If your therapist spends in excess of 10 minutes communicating via phone/email with you, a prorated hourly fee for the time spent may be applied to your account. The client will be responsible for these charges, as they can not be billed to insurance.

Full payment (or insurance co-payment) is expected at the time of the service. You may pay with cash, check or credit card. A $30.00 charge will be assessed for returned checks. Clients whose account is in arrear may be unable to schedule a session until account is paid in full. You are responsible for any balance not paid by your insurance.

We value our time with our clients and craft our schedule accordingly. If a client does not show up for an appointment, or provide at least 24 hours notice of canceling the appointment, a $80.00 charge will be assessed for the each occurrence. Upon the third occurrence, payment will be expected in advance of session. Exceptions may be warranted in the event of an emergency.

Client Responsibility: In order to receive the full benefit from the counseling relationship, it is essential that you are honest and put forth effort into the counseling process. If you are currently receiving services from another mental health professional, we expect you to inform us of this. You are responsible for keeping appointments and paying your bill on time.

Physical Health: There is a strong connection between physical and emotional health. As a part of the initial evaluation you will be asked to give the name of your primary care physician, describe your medical history, and list all medications you are currently taking. It is recommended that you have a physical examination if you have not had one in the last year.

Record Keeping: Clients will have a file created in his, her, or their name(s). The purpose of that file is to help the therapist remember relevant information and to carry out his/her responsibilities effectively and efficiently. Files will be maintained for 7years after termination of the counseling relationship, at which time the file will be destroyed.

Contact with your Counselor: Clients are requested to contact their counselor by email or phone (due to the nature of our work, you may need to leave a message). We strive to return all messages/emails by the end of the next business day.

Clients who need to cancel appointments are requested to do so at least 24 hours in advance. This can be done most simply by visiting your client account at: https://app.acuityscheduling.com/schedule.php?owner=13723806, or by phone/email,

If for some reason, your therapist must cancel an appointment, he or she will contact you. Every attempt will be made to provide at least 24 hours notice of the cancellation. If you do not wish for us to contact you via phone or email, please notify us so that we can discuss an alternative arrangement.

Social Media Policy: Due to the confidential nature of the therapeutic relationship, our practitioners do not accept friend, follower, or message requests from clients on any social networking sites (Facebook, Instagram, Twitter, LinkedIn, Snapchat, etc). Connecting on social media can compromise your confidentiality and our respective privacy.

Restoration 23

Emergency Situations: In case of a severe mental health or life-threatening emergency, please **call 911** or **proceed to the nearest hospital emergency department** before contacting your therapist. If you are under the care of a psychiatrist, and your emergency is not life-threatening, you may also contact his/her office.

Additional crisis hotline numbers are listed below:

24-Hour Crisis Line: (770) 422-0202

National Suicide Hotline: (800) 784-2433, or (800) 273-TALK

I have read the information above and choose to enter into a therapy relationship under the circumstances described.

Client or Authorized Representative	Date	Relationship to the Client
Therapist	Date	

Restoration 23

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient, you have following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.
If you have any questions about this Notice, please let your counselor know.

Effective Date of this Notice	1/1/2018
Contact Person	Sarah Zipfel
Phone Number	(770) 515-9023

Acknowledgment of Notice of Privacy Practice

*"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way."*

_____
Patient or if minor Representative Name (please print)

_____ _____
Patient or Representative Signature Date

Restoration 23

CLIENT INFORMATION FORM

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ **Social Security #:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Best phone for reaching you or leaving discreet messages. Please indicate any restrictions.

_____

Education: _____ **Highest Degree Obtained:** _____

Occupation: _____

Name of Employer: _____ **Phone:** _____

Spiritual Resources: _____ **Religious Affiliation:** _____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Briefly describe your concern(s)which prompted you to seek counseling at this time:

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

Restoration 23

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____
Do you consume caffeine? YES NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____
Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _____

_____

Previous Hospitalizations: (Approximate dates and reasons):_____

_____

_____

Previous treatment with a psychiatrist, psychologist, or other mental health professional? YES NO
Name:_____Dates:_____Reasons:_____

RELATIONSHIP STATUS:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT
Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

FAMILY MEMBERS:

Relationship:	**Name:**	**Age:**	**Describe Relationship**
Spouse/Partner			
Mother			
Father			
Other Primary Caregivers			
Brother(s)			
Sisters(s)			
Children			

Describe any relationship problems you are experiencing at this time:

Restoration 23

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM(S):

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

_____

_____

_____

_____