Informed Consent

I'm hopeful that your experience in therapy will be meaningful. The following information is designed to provide you with some idea of what to expect. Counseling has been shown to have many benefits, such as improved relationships, solutions to specific problems, and significant reductions in feelings of distress. It can also bring up unpleasant emotions associated with what is discussed in therapy and individuals receiving therapy may feel worse, emotionally, before they begin to feel better. Each individual is unique therefore each experience of counseling will be unique, as well. Goodness of fit between the client and therapist is extremely important and something only you can decide for yourself. Likewise, I need to feel as though I can offer you something positive to continue contact. The initial session focuses primarily on information gathering of your current concerns and history. I view counseling as a collaborative process between you and I, so please feel free to express yourself and ask questions at any time.

Confidentiality

Georgia law entitles you to privileged communication when talking with a Licensed Clinical Social Worker. What you talk to me about is confidential, with a few exceptions listed here: 1. I believe you or someone else to be in immediate, life-threatening danger, 2. I suspect a child, disabled individual, or elderly person to be in danger, 3. I am ordered by a court to release your psychological record, 4. you sign a Release of Information directing me to share information with another party. If my professional opinion is that you are in danger of harming yourself or others, your signature below gives me permission to contact someone close to you (e.g., emergency contact) and disclose relevant information in regard to the safety concern. Additionally, I may consult with other mental health professionals if necessary or beneficial, however this will not include identifying information. For more information see The Georgia Notice Form for Privacy, which you have received today.

Please initial that you have read and understand confidentiality terms: _____

Technology Statement

In our ever-changing technological world, there are various ways that we could potentially communicate. It is of utmost importance that we maintain confidentiality, respect boundaries and preserve our therapeutic relationship. As a result I've compiled information to help clarify the appropriate and inappropriate uses of technology within our relationship. Cell phones may not be completely confidential but are widely used by most all of us. Text messaging and emailing are not fully secure means of communication. I typically do not engage in either methods of communication with clients however in rare circumstances texting for scheduling purposes can be beneficial to quickly communicate. If this is something you are comfortable with, please initial here: _____. It is my policy not to engage with clients on any form of social media (Facebook, Instagram, Google, etc.). At this time I do not offer sessions over the Internet, as I cannot guarantee confidentiality. In unique circumstances I am willing to consider this option on a HIPPA compliant platform within the state of Georgia if it is clinically indicated. Please inquire if you think this may apply. As previously stated, technology changes rapidly

therefore I will modify these policies as needed and am glad to discuss any of the above information.

Please initial that you have read and understand the technology statement: _____

Fees

You will be responsible for payment at the time of service in the form of cash, check or card. Exceptions will be agreed to in advance.

If you choose to use health insurance, you will be responsible for the copay at the time of service. I will bill insurance as a courtesy but you are responsible for any fees not covered. If your insurance company denies a claim you are responsible for all fees at my standard fee rate, which is listed below. Copays are estimates based on your coverage but are not confirmed until the claim is filed. Insurance companies require me to share with them your personal information as a condition for reimbursement so I will need your permission to do this in the form of a Release of Information. If you choose to seek counseling services that are out of network for your insurance plans, I can provide a statement so that you may seek reimbursement. Please inquire if you are interested in this. If you are paying out of pocket my initial session is $115. Thereafter, a session fee is $100 per session. Sessions are by appointment only and are 50-60 minutes.

Please initial that you have read and understand fee terms: _____

Cancellation Policy

When we schedule an appointment we are both committing to spend that time together. Because I am setting your appointment time aside exclusively for you, **please give a minimum of 24 hours notice if you need to cancel**. There will be a *full session charge* (not your copay) for missed appointments or late cancellations. Please note that insurance cannot be billed for appointments nor does the fee apply to your deductible. Emergencies will be considered and in that instance please be in touch as soon as possible. Your signature below authorizes me to pursue payment via a collection agency in the event of failure to pay charges within 30 days of service or missed appointment. If you are more than 15 minutes late for an appointment we will reschedule so that we can spend our full session together, and you will be charged for the full session.

Please initial that you have read and understand cancellation policy terms: _____

Credit/Debit Card Pre-Authorization Form

I authorize Sarah K. Chatfield to keep my signature on file and to charge my credit, debit, or HSA card for charges per my insurance plan or private pay fees per therapy/counseling session. I also authorize charging my credit card for the full session fee for any appointment that is not kept or cancelled in accordance with our policy. I understand that missed appointments are not reimbursed by insurance.

I understand this is valid for two years unless I cancel the authorization in writing. I agree not to dispute charges ("charge back") for sessions I have received or not cancelled 24 hours prior to the scheduled appointment. I further authorize my provider to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

_____ _____

Client signature Cardholder name

In Case of an Emergency or Crisis

I am set up to provide outpatient services to accommodate individuals who are reasonably safe and resourceful. I am not immediately available at all times. If at any time this does not seem like sufficient support, please talk with me about this so we can explore appropriate options. Generally I will return phone calls in 24-48 hours. My phone number is 706-621-3716 and my voice mail is confidential. In the event that you have a mental health emergency in which there is a question of imminent risk or harm, please do not wait for a call back but instead make contact with one of the following:

- Call the Georgia Emergency Crisis line at 1-800-715-4225
- Call Summit Ridge Hospital 678-442-5858
- Call Athens Regional Medical Center 706-475-7000
- Call St. Mary's Hospital 706-389-3000
- Call 911
- Go to the nearest emergency room

Your signature below gives me permission to share your protected health information with a licensed mental health practitioner designated by me, if the need arises due to my absence and/or due to emergency circumstances.

If you have an after hours crisis that is not life threatening you may call this therapist although the same parameters listed above will apply with regard to availability. Crisis calls lasting beyond 10 minutes are billed at a rate of $75 per 30 minutes and cannot be billed through insurance. Repeated crisis calls are a sign for a need for a higher level of care and will be discussed in session.

Please initial here that you have read and understand emergency/crisis terms: _____

I have read and understand the above information and I give consent to receive counseling services under these conditions.

_____

Printed Name and Signature of Client Date

_____

Witness/Therapist Signature Date