Covenant Counseling & Family Resource Center

INFORMED CONSENT & AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome to Covenant Counseling & Family Resource Center (CCFRC). This brief guide presents some of the basic information that will help you understand CCFRC and facilitate our work together.

Please initial each section below

I. Intake Evaluation

Initial _____

During the first session, a therapist will assess your needs and determine the most appropriate type of counseling for you in your current situation. The therapist will explore your goals for counseling, who needs to be involved, and the procedures that will be followed in therapy. If appropriate, a referral will be made to another heath professional. You will be asked to sign this consent to treatment form.

II. Appointments, Cancellations & Emergencies

Initial _____

Each therapist schedules their own appointments. Each session is approximately 45-50 minutes in length. CCFRC has 7-day week phone coverage for cancellations. You are responsible for cancelling appointments as soon as possible whenever it becomes clear you will be unable to keep a scheduled appointment. **The full established session fee will be charged for appointments not cancelled at least 24 hours in advance.**

If an emergency situation arises that requires immediate attention, you may call the emergency National Suicide Hotline at 800-784-2433, Georgia Crisis Line at 800-715-4225 or dial 911. If a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911, or go to a hospital emergency center.

III. Fees, Payments, & Bills

Initial _____

Since CCFRC is a non-profit counseling center we seek to provide services within its financial means. This center operates with a Standard Fee, which may be adjusted according to your need. The therapist will talk you about the fee during the first session and set a fee that reflects your current financial situation. CCFRC asks that your account be kept current and payments be made at the conclusion of each session. We accept cash, check, and major credit cards. If you are paying by check, please make the check payable to CCFRC. If payment made by check is returned by the bank, you will be responsible to pay the original fees due plus any bank charges CCFRC may incur for insufficient funds.

Should your fees not be paid for two or more sessions, no further sessions will be scheduled until the balance is paid and/or payment arrangements have been made with your therapist. At the conclusions of treatment, all outstanding fees must be paid upon termination.

Should you arrive late to an appointment, please note that the full amount for the session will be charged and the appointment will end at its originally scheduled time. **Payment is expected at the end of each session.**

IV. Privacy & Confidentiality

Initial _____

The information disclosed by you during sessions and the written records pertaining to those sessions are generally confidential and may not be released to any third party without written authorization from you, except where required or permitted by law. You understand that all records of communication between you and your therapist remain the property of CCFRC. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which CCFRC and/or your therapist is court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices" (copies available on CCFRC's website: https://covenantcounseling.org/).

If you participate in couples or family therapy, confidential information about treatment will not be disclosed unless all person(s) who participated in the treatment provide their written authorization to release such information. Furthermore, it is important that you know that our therapists utilize a "no secrets" policy when conducting family or marital/couple therapy. This means that a therapist will not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask your therapist about the "no secrets" policy and how it may apply to you.

V. Risks and Benefits of Therapy

Initial _____

Psychotherapy is a process where a myriad of issues, events, experiences and memories will be discussed for the purpose of creating positive change. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between a client and a therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which your perceptions and assumptions will be challenged, and different perspectives offered. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility.

During the therapeutic process, some individuals find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should discuss with your therapist any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, a therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

VI. Child/Adolescent Clients

Initial _____

A client who is sixteen (16) years old or younger, must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document giving sole medical decision custody must be presented.

VII. Therapeutic Relationship

Initial _____

Your relationship with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you.

VIII. Termination and Evaluation

Initial _____

Although you may end treatment at any time, notification of your intention to terminate therapy is important. It is recommended that you have one last face-to-face termination session with your therapist. An ongoing client receiving psychotherapy at CCFRC, shall understand that if an appointment is missed/cancelled, and a session is not re-scheduled within sixty (60) days for a future appointment, CCFRC will understand it as notice that services are voluntarily terminated resulting in the closure of the therapeutic file. However, a client can request to resume psychotherapy services in the future by contacting their therapist directly to schedule an appointment.

IX. Professional Consultation

Initial _____

Professional consultation is an important component of a healthy psychotherapy practice. As such, your therapist may regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, no personally identifying information regarding you or your situation will be revealed.

X. Patient Legal Matters

Initial _____

Your CCFRC therapist does not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. The CCFRC therapists have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. CCFRC therapists do not provide records or testimony unless compelled by a Judge to do so. Should CCFRC or one of its therapists be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, including issues pertaining to custody/guardianship of minors, there will be a fee for preparation, travel, and any additional time the therapist and/or staff have spent to be available for such an appearance at each therapists usual and customary hourly rate for such services of $_____per hour.

In general, the HIPPA Rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of "PHI" (Protected Health Information) be made by alternative means such as sending information to the individual's office instead of his/her home.

XI. E-mail Communication

Initial _____

Some patients prefer to communicate via e-mail. To protect your privacy, it is preferred to only use email for arranging or modifying appointments and limited administrative purposes. Please do not email content related to your therapy sessions, as email is not completely secure or confidential. Although information stored on our computer is encrypted, e-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. In addition, once the e-mail is received by you, someone may be able to access your e-mail account and read it. This may include your employer if you use a work-related e-mail address. E-mail should be considered to be more similar to a "post-card" than to a sealed letter, and for that reason, CCFRC discourages sending sensitive information via e-mail. Please initial the options that meet your needs. You can change this at any time by communicating with your therapist in writing.

You should also know that any emails CCFRC or its therapists receive from you, and any responses sent to you become a part of your health record.

_____ I do not wish to receive any information via e-mail.

_____ I understand the risks of unencrypted e-mail and do hereby give permission for CCFRC and/or its therapists to contact me or to reply to me via unencrypted e-mail for only appointment scheduling and limited administrative purposes.

Preferred e-mail address(es): _____

_____

XII. Voice/Text Phone Communications

Initial _____

You may contact your therapist between sessions by leaving a voicemail at (770) 985-0837 ext._. Therapists check their voicemail messages throughout the day (but not overnight and less often on weekends and holiday), and will make every effort possible to return your call by the next business day. Therapists do not have access to your personal contact information while they are away from the office, so it is important that you please leave a clear message with your call back number and best time(s) of day to reach you. Please understand that CCFRC is not a crisis center. If you have a crisis, emergency, or need immediate help, please refer to the Emergency/Crisis numbers provided above.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:

_____ Okay to leave message with details.
_____ Leave message with only call back number.
_____ Okay to speak to spouse.
_____ Other:_____

Cell Phone:
_____ Okay to leave message with details.
_____ Leave message with only call back number.
_____ Other:_____

Work Telephone:
_____ Okay to leave message with details.
_____ Leave message with only call back number.

Written Communication:
_____ Okay to mail to my home.
_____ Okay to mail to my work.
_____ Okay to fax to designated phone #_____

I give CCFRC permission to use the disclose PHI necessary to carry out Treatment, Payment or Operations. This also indicates a good faith effort was made on behalf of the CCFRC. I understand that the privacy practices of CCFRC have been disclosed to me. This information will stay on records for five (5) years.

Acknowledgement

By signing below, you as the client(s) acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. Client(s) have discussed such terms and conditions with the therapist and have had any questions with regard to its terms and conditions answered to client(s)' satisfaction. Client(s) agree to abide by the terms and conditions of this **Informed Consent & Agreement for Psychotherapy Services** and consent to participate in psychotherapy with the therapist. Moreover, client(s) agree to hold their therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client Name (PRINT)	Signature of Client (or authorized representative)	Date
Client Name (PRINT)	Signature of Client (or authorized representative)	Date

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

Name of Responsible Party (PRINT)	Signature of Responsible Party	Date