LAURA LADEFIAN
COUNSELING

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Thank you for choosing me to be your psychotherapist. I look forward to working with you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of the therapeutic process. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

I am a Licensed Professional Counselor (LPC007425), Registered Play Therapist-Supervisor (S1987), and Certified Professional Counselors Supervisor (#547). I received Master of Science and Education Specialist degrees in Professional Counseling from Georgia State University. Additionally, I received post-graduate training in Play Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Child-Parent Relationship Therapy. Since 2010 I have been serving children and families in a variety of settings including children's hospitals, public schools, and Children's Advocacy Centers. My specialties are play therapy and parent-child relationships. I serve children and families coping with adjustment to life changes, grief and loss, anxiety, trauma, and depression.

Theoretical Views & Client Participation

I believe in each individual's resilience and potential for growth. Throughout the therapeutic process I seek to identify and encourage your strengths and interests. By creating a safe and welcoming environment within the therapeutic relationship, my hope is that you can gain a greater understanding and acceptance of yourself. Some individuals and families are able to achieve their goals in a matter of a few sessions, however for others therapy is a long-term process. Therapy is most efficacious when the client takes an active role- you get out of counseling what you put into it.

Professional Relationship

Psychotherapy is a professional service I will provide for you. Because of the nature of therapy, our relationship must be limited to that of therapist and client. The relationship between client and therapist is an evolving and collaborative process that requires work and commitment from everyone involved. Like any meaningful relationship, the client-therapist relationship is built over time and will grow and change. Despite the feelings of closeness that some clients and therapists will experience during the course of the therapeutic work, therapists are prohibited by their ethical codes to have personal or professional relationships of any other nature with their clients. This is believed to be in the best interest of all parties as well as the therapeutic process. To maintain your confidentiality and respect your privacy if we see each other in public I will not address you, although you are welcome to decide whether or not your feel comfortable addressing me. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, we will not be able to continue a personal relationship. In sum, it is my duty to always maintain a professional role. Please understand that when a period of 90 days lapse where no appointments have been scheduled and the client does not return the therapist's contact, your case will be closed. You are always welcome to contact me with future needs, but I am unable to remain professionally engaged when a client is not participating in the therapeutic process.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia professional licensing board that governs my profession.

Due to the nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless. Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office filing room. All of our communications will be kept confidential by me, with the following exceptions:

(1) you have asked that I communicate with a third party and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) I become aware of the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record of respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

I, _____, have received a copy of this office's Notice of Privacy Practices and understand that this office operates in compliance with the Health Insurance Portability and Accountability Act.

Initial: _____

Privacy, Confidentiality, and Rights in the Treatment of Minors

The treatment of a minor child can only be initiated by that child's legal guardian. Similarly, the law grants legal guardians full access to the records of a minor child. This includes health information and session content. However, because a trusting relationship is the cornerstone of counseling I ask that you refrain from asking me for a direct play-by-play of your child's sessions with me. I am happy to provide updates regarding the treatment plan and your child's progress. As always, if a risk to your child's health or safety becomes apparent you will be informed. I will first encourage your child to inform you, however if your child is unable to do so I will be the one to inform you. I welcome you to discuss your expectations with me and for us to determine a manner of sharing information that is comfortable for parent, child, and therapist before we begin the counseling process. If your child is old enough to understand confidentiality we will discuss as a group the bounds of confidentiality and your rights as the guardian.

Parents without legal guardianship have no legal rights to records and are bound by the parameters of standard confidentiality laws. For children whose parents are in the process of divorce or are already divorced, a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge is required to be kept on file.

The services offered by Laura Ladefian Counseling LLC are not forensic in nature. Recommendations regarding custody and parental fitness evaluations are outside of the scope of my practice. If you are in need of these services, please let me know and I will provide a list of referrals to experts in that field of work. Additionally, I do not offer fact or expert witness testimony in civil cases. In the event that I am subpoenaed by an attorney to testify in a civil proceeding or to consult with your legal counsel my fee is $250.00 an hour plus mileage and expenses incurred. A $2,500 retainer to be paid by your attorney's office is required before the start of such services.

Initial: _____

Electronic Communication and Use of Technology

E-mail, text or other forms of electronic messaging can be helpful tools for communicating between sessions regarding non-clinical issues such as scheduling and other logistics. If you choose to communicate with me via email or text message, please acknowledge that these forms of communication are not always completely secure, and therefore I cannot guarantee client confidentiality via any of these methods. If privacy is a concern for you, I invite you to call me via telephone or to wait for our session time to communicate. Electronic communication may be used to initiate and obtain information about services, schedule appointments, transmit documents, and similar purposes initiated by the client or therapist. Electronic communication is not an appropriate means of terminating services or contacting therapist in the event of a crisis situation whereby your safety or the safety of others may be at risk. Please also do not use electronic communication to bring up any therapeutic content or issues. All email correspondence and text messages containing clinical information will be printed and kept as part of your clinical record.

In Case of an Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I am not available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls and emails within 1 business day. If I am out of the office a voicemail recording and email notification will inform you of my return date as well as emergency contact information. Please note that at this time I am unable to notify you of office leaves via text message. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call Ridgeview Institute at (770)434-4567 or Peachford Hospital at (770)454-5589
- Call 911
- Go to your nearest emergency room

Structure and Cost of Sessions

Sessions are $175 per 50-minutes. This includes intake assessments, parent consultations, individual and family therapy. Half hour sessions are $105 and 75-minute sessions are $265. Telephone calls that exceed 15 minutes in duration will be billed at $3 per minute. The fee for each session is due at the conclusion of the session. Payment is accepted in the form of cash, check, Visa, Mastercard, Discover, American Express, Health Savings Account, and Flexible Spending Account. Please note that there is a $35 fee for any returned checks.

Initial: _____

Insurance companies have many rules and requirements specific to certain plans. If you choose to utilize your out of network benefits it is your responsibility to find out your insurance company's policies and to file for reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

I require a credit card on file to reserve appointment times. You may elect to use another form of payment at the time of service. In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions. *(COVID related cancellations are not subject to my cancellation policy)*

Credit Card: _____ Exp: _____ CSC: ____ Billing Zip Code:_____

By signing below, I authorize Laura Ladefian Counseling LLC to charge the above credit card for services rendered as well as for any applicable missed appointment fees.

_____ _____
Client Signature Date

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you.

_____ _____
Client Name Date of Birth

_____ _____
Client/Guardian Signature Date

_____ _____
Therapist Signature Date