INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Thank you for choosing me to be your counselor. 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 the counseling relationship. 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 (M.S.) and Education Specialist (Ed.S.) degrees in Professional Counseling from Georgia State University. Additionally, I received post-graduate training in Play Therapy and Child-Parent Relationship Therapy. Since 2010 I have been supporting individuals and families in a variety of settings including a Children's Advocacy Center, Children's Healthcare of Atlanta, Cobb County School District, and in private practice.

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 longer-term process. As a client, you are in complete control, and you may end your relationship with me at any point. In order for therapy to be most successful, it is important for you to take an active role. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping.

If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or I do not hear from you for a period of 45 days, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming counseling is always an option.

Professional Relationship

Counseling 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.

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 counseling, 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 together to achieve the best possible results for you. Please be aware that changes made in therapy may impact other areas of your life, including your relationships. It is my intention to help you manage changes in your world 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 exploring sensitive areas of your life. Once you and I are able to identify your hopes and wishes for the therapeutic process, we will work collaboratively towards these goals.

For the safety of all my clients, their accompanying family members and children, and other therapists in the building I maintain a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises. I reserve the right to contact law enforcement officials and/or terminate treatment with any client who violates my weapons policy.

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 which is remained locked at all times that I am not present. 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 counselor. 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. However, because a trusting relationship is the cornerstone of counseling, I ask that you refrain from asking me for direct play-by-plays of your child's sessions with me. I am happy to provide updates regarding the course of therapy 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.

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.

As a counselor there is a dual relationship that I am ethically required to avoid. This is providing counseling while also providing a legal opinion. These are considered mutually exclusive unless you hire a professional specifically for a legal opinion, which is considered "forensic" work and not counseling. Forensic services are outside of the scope of my practice. Therefore, by signing this document, you acknowledge that I will be providing counseling only and not forensic services. You also understand that this means I will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities. However, if for some reason I am compelled to testify to a court of law, I will require an upfront retainer of $3,000 and my billing rate will be $500 per hour. Additionally, if I receive a valid subpoena to produce or a valid request for production of documents, I will need to charge you reasonable and customary fees based on state and Federal guidelines of $1 per page or maximum allowed by law to produce those records. If a summary of treatment is accepted instead of the entire set of records, I charge my hourly rate for the time to produce this summary.

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 the Georgia Crisis & Access Line at 1-800-715-4225
- Call or text 988 Suicide Prevention & Crisis Line
- Call 911
- Go to your nearest emergency room

Structure and Cost of Sessions

Sessions are $185 per 50-minutes. This includes initial intake appointments, parent consultations, individual and family therapy. Half hour sessions are $110. The fee for each session is due at the conclusion of the session. Included in your session fee is 15 minutes of case coordination. This includes telephone calls, reading & responding to emails, and any communications with other providers that you have requested of me. Any time spent outside of session exceeding this 15 minutes is billed at my hourly rate for the time spent. Please note that I am unable to schedule or hold appointments when an unpaid balance of 2 sessions has accrued. Payment is accepted in the form of cash, check, debit or credit card, Health Savings Account, and Flexible Spending Account. Please note that there is a $30 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.

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. *(Appointments canceled due to infectious illness 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.

By signing below, you are 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 authorize me to begin counseling with you.

____ ______________________
Client Name Date of Birth

____ ______________________
Client/Guardian Signature Date

____ ______________________
Therapist Signature Date