INFORMATION and CONSENT FOR TREATMENT

Thank you for choosing me to assist in your mental health treatment. Please take a moment to review my philosophy and guidelines for providing counseling services.

Cancellations: Cancellations must be made within 24 hours of scheduled appointment time. If notification is not received within that time, the missed appointment will be billed at the regular rate. If no one is available to take your call, please leave a message on my voicemail **(678) 242-9308** or e-mail **dustinsmithlcsw@gmail.com**

Fee for service: A 50 minute session will be billed at an hourly rate.

Cost of Sessions: I agree to provide psychotherapy for the fee of $125 per 50 minute session. An extended session, 75 minutes, will be for the fee of $150. The fee for each session will be due at the conclusion of the session. Please note that there is a $25 fee for any returned checks and subsequent appointments will only be scheduled if your account is paid in full. A $3.00 credit card processing fee is due for any credit card payment under $50.00.

Court:
If Therapist is subpoenaed to court the fee for service is $300 an hour.

E-mails and Phone Calls outside of session:
A phone call will be billed to the customer the same as being involved in a session. Payment is due for the phone call at the next session.

E-mails might not be answered if Therapist feels the issue would be better addressed during the next session. More than one e-mail a month, which needs to be responded to will result in a $20 dollar fee for service. Payment is due at the next session.

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations/cancellations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:
Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations/cancellations.** Please do not bring

up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

Confidentiality: I am legally bound by our professional code of ethics to maintain client confidentiality, with the following exceptions:

1. To disclose reports of child/elder abuse.
2. To prevent clear and immediate danger to self or others.
3. When court ordered to do so.
4. Duty to warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to notify legal authorities.
5. If there is a signed consent to release information.

Consultation and Supervision: Occasionally, when an individual or family are not making progress in therapy, we as professionals may wish to obtain consultation and/or supervision from a qualified professional outside the agency to assist us in providing the best possible services. If we determine that there is a need for consultation we will discuss this option with you and obtain your permission.

Record Keeping: 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 at 360 Therapy's locked office. I also use a HIPAA compliant software system called Therapynotes, which will be used to store PHI electronically.

Consent for Release of Information: If it is necessary to contact other agencies to give or receive information about you, I will obtain your written permission.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

Initials: _____

Treatment Consent Form

Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed I perform professionally. This form documents that the client has consented to treatment with Dustin Smith, LCSW.

This form provides evidence that no guarantee is made by myself the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the treatment provider. If you have any questions concerning this or any other matter, it is your responsibility to ask the treatment provider. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, _____
(Print your name)

do hereby voluntarily consent to the care and/or treatment by _____, I am aware that the practice of medicine, psychiatry, clinical psychology, clinical social work, and other therapy by the licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of this treatment.

I am aware that I am an active participant in the assessment and counseling process and that I share responsibility for treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way as is applicable.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____ _____
(Sign your name) (Date)

_____ _____
(Witness) (Date)

Initials: _____