Mary Stuart Neill, LPC
Marietta Counseling for Children and Adults, LLC
2440 Sandy Plains Rd. Bldg. 13, Suite 300
Marietta, GA 30066
770.971.9311 ext 7

Information for Clients and Informed Consent

About your therapist

I am a Licensed Professional Counselor, working toward Registered Play Therapist and Registered Play Therapy Supervisor credentials in the state of Georgia. I have a Masters degree in Counseling with rich experience providing psychotherapy services for children, adolescents and families.

About Marietta Counseling for Children and Adults

Marietta Counseling for Children and Adults (MCCA) is a "dba" for Marietta Counseling, LLC a limited liability company in the state of Georgia established to provide a facility where therapists can provide counseling and psychotherapy services for children, adolescents and adults. MCCA provides fully equipped office space and peer consultation contracting with both fully licensed therapists and associate licensed therapists who all provide therapy services. I am contracted with MCCA to provide therapy services for children, parents, families and individual adults.

Benefits and Risks of Counseling

Benefits of counseling have been shown in many well-researched studies. However, change and the processes involved in creating positive change can at times be difficult and unsettling. In some cases, especially with children, symptoms worsen before improving. Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed.

After Hour Support and Emergencies

Marietta Counseling for Children & Adults is not an emergency services agency. I do not provide emergency services. If you have a life threatening or mental health emergency please call 911. After you call 911 you may call me during business hours at 770-971-9311 ext. 9 and leave me a confidential voicemail. I will call you back when I have finished all sessions or between sessions if possible.

Other after hour Mental Health Resources (not to be substituted for calling 911 with emergency):

1. Ridgeview Institute at 770-434-4567
2. Peachford Hospital at 770-455-3200
3. Cobb Mental Health Crisis Line at 770-422-0202
4. Lakeview Behavioral Health at 678-713-2600

Client Name: _____ Date of Birth: _____

Parents/Guardians:(if child client) _____

Address: _____ City/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer/Occupation/School Info/Grade: _____

Emergency Contact (Name, Relationship, Phone): _____

Referred by: _____

What is the primary reason you are seeking counseling for you and/or your child/adolescent at this time?

_____

_____

_____

_____

When did you first notice the problem, issue, or symptoms?

_____

_____

_____

_____

What have you already tried to improve the problem or symptoms? What has helped or has not helped?

_____

_____

_____

_____

Have you or your child or family ever been in counseling before? If yes, please provide approximate dates and provider. What helped or did not help?

_____

_____

_____

_____

Please list current medications, dosage, prescribing physician and office telephone number, and length of time taking this medication.

Please sign to indicate permission to consult with prescribing physician:

Have you or your child (if child client) ever expressed or experienced thoughts or feelings of suicide, self harm, or harm to others? If yes, please provide approximate time frame(s) and details.

Please describe any significant medical history (including chronic conditions, hospitalizations, surgeries, premature birth, etc.)

What goals or changes would you like to see accomplished by your child and/or family through counseling?

Please list anything else you would like me to know before we begin our work together.

Confidentiality

It is a client's legal right that our sessions and my records about you are kept private. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are exceptions as follows:

1. When the client signs a release of information requesting that the therapist divulge information.
2. When a client is believed to be a danger to self or others.
3. When a minor is suspected of experiencing physical or sexual abuse, your therapist is legally and ethically bound to make a report to the Department of Family and Children's Services.
4. When disclosure is required by a valid court order.
5. The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Additionally, I am happy to provide paperwork for you to file with your insurance company; however, insurance companies require a diagnosis for reimbursement. Confidentiality cannot be guaranteed by your therapist once information is given to insurance companies.

My professional supervision and/or consultation with other licensed therapists are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality.

If you should choose to communicate with me via email, confidentiality cannot be guaranteed and information may be accessible to others. We can communicate confidentially through hushmail. Clients may choose to set up a free hushmail account at www.hushmail.com. My hushmail address is marystuart.neill@hushmail.com . This system encrypts the content of your email and mine and protects your private information. Please indicate your preference by checking Yes for regular email or that you plan to sign up for hushmail and signing here:

Yes, I understand my email is a limit to confidentiality and I do authorize you to communicate with me via email: _____ (signature)
Please provide the email address where you authorize me to send you emails:
_____

_____ I plan to set up a hushmail account to communicate with my therapist. I will provide the therapist with this email address once the account is established.

In the case of my death or major medical incapacitation, all of my records will be accessed by Cecelia Myers, LPC, CPCS, NCC, Owner and Director of Marietta Counseling.

More on Confidentiality:
In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.
In **working with couples and families**, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I ***will not be a "secret keeper" nor will I facilitate secret keeping..*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it.

Divorce and Custody

I am not a custody evaluator and can not make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.*

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

1. I require a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session BEFORE I am able to meet you child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

2. I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

3. I ask <u>all my clients</u> waive right to subpoena me to court. This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child(ren). It is my experience that my appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if you would prefer.

4. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of $120/hour of my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $120 per hour.

I understand these policies and hereby waive any and all rights to subpoena Mary Stuart Neill, LPC and her clinical record on any current or future legal proceedings.

Printed Name_____ **Signature** _____**Date**_____

Printed Name_____**Signature**_____**Date**_____

Scheduling and Cancellations

A minimum of 24 hours is required to cancel an appointment. If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, there will be a $75 charge billed. If there is a true, unavoidable emergency or serious or contagious illness, please call as soon as possible and I will work with you to reschedule and you may request waiver of the 24 hour policy.

Session parameters

Play Therapy Sessions are 45 minutes. Parenting sessions, individual counseling sessions and family sessions are 50 minutes. Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance…

All fees are paid directly to Marietta Counseling. Marietta Counseling does accept Master Card, Visa and Discover.

If I am not a provider for your insurance, I will be happy to provide paperwork for you to file with your insurance company for out of network reimbursement. I cannot guarantee your insurance company will reimburse for my services.

A limited number of reduced fee slots are available with application and are extended based on financial need. Please ask me about reduced fee options. I will be more than happy to discuss alternative payment agreements at our initial intake session. A reduced fee agreement will be signed once application is agreed upon.

There is a **$25 fee for any returned checks.** That $25 fee is due at the time of your next session, along with the payment for that session. If I receive two (2) returned checks from you, I will require that you pay using cash or credit card only from that point on.

Initial Intake Session: $150

All other Sessions: $120

Preparation of Summaries of Treatment or Letters at request of client: $75 per item requested.

Court Related and/or Child Specialist Work for Collaborative Law Cases: $120/hour of any and all time spent on the case.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law to do this and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems. I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for services, or for other business activities, which are called in the law "healthcare operations". After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat you or your child. Of course, I will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

1. When there is a serious threat to you or your child's health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official legally requires me to do so.
4. For workers compensation and similar benefit programs.

There are some other situations like these that do not happen very often. They are described in the long version of NPP.

Client Records

You should be aware that, pursuant to HIPAA, I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of $35 charged for copying and mailing the record for release.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number:

Georgia Composite Board of Professional Counselors,
Social Workers, and Marriage and Family Therapists
237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

Signature indicating I have read and received the Notice of Privacy Policies:

_____	_____	_____
printed name	signature	date

Agreement to Enter into Counseling Services and Fee for Services Agreement

I have read or had read to me and understand all the information in the above paperwork. I have had a chance to review and ask questions and have all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling. I also hereby acknowledge that I have received the Notice of Privacy Policies.

Every time I schedule an appointment with my therapist I understand that I am entering into a contract with Marietta Counseling and for the professional time and services provided for that appointment time. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agreed that my fee for sessions will be $_____and I agree to pay this fee at the time of each session. I understand that MCCA does not reimburse for cancelled appointments that were paid for in advance but that any such fees will be credited to your account and applied to future services provided.

I understand that Marietta Counseling's cancellation policy requires 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session. **I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged $75 for the appointment. I hereby authorize MCCA to charge my Visa/ Master Card/ Discover (circle one) credit card number_____exp. date_____cvc code_zip code _____**

If indeed I fail to observe this cancellation policy. I also understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with my therapist directly and request a waiver of this policy.

Client (or parent/legal guardian of child client) Printed Name_____

Client (or parent/legal guardian of child) Signature and date_____

Therapist Signature and date_____