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Marietta Counseling for Children and Adults
2440 Sandy Plains Rd. Bldg. 25
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770.971.9311 ext 3

Information for Clients and Informed Consent

I am a Licensed Professional Counselor in the state of Georgia (LPC #6862). I have a Masters degree in Psychology with a Professional Counseling Specialty. I have rich experience providing psychotherapy services for teens and adults. I am also a Certified Professional Clinical Supervisor (CPCS #676) and a Registered Yoga Teacher (RYT) through the Yoga Alliance.

About Marietta Counseling for Children and Adults

Marietta Counseling for Children and Adults is 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. I am contracted with MCCA to provide therapy services for adolescents, parents, families and individual adults.

Benefits and Risks of Counseling

Benefits of counseling have been shown in many well-researched studies. People who are depressed often find their mood lifting. Anxieties preventing normal functioning can be mastered. Therapy can allow people to work through what is bothering them until their feelings are naturally resolved. Skills in relationships and communication often greatly improve. Counseling may help clients to develop and maintain a sense of balance in life followed by more lasting contentment, satisfaction and skills for coping with inevitable challenges life presents.

Risks of counseling include feeling uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding way to balance. It is not uncommon (especially with adolescents and those with a history of trauma) for symptoms to worsen before improving. Clients may recall unpleasant memories.

Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling and understand that therapy is not a quick fix, transformational results are often observed.

Office Hours

I am typically in the office Tuesday through Friday and my hours will vary. I have availability to see clients after school or after work hours. My last appointment available will start at 8pm. Please be aware that sliding scale appointment times **will only** be available during "non-peak" hours. If you leave me a voicemail, I will return it within 24-48 business hours.

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. 3 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 678-713-2600

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 ("superbill") 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. Please indicate your preference by checking Yes for regular email and signing here:

_____YES, I understand my email is a limit to confidentiality and I do authorize you to communicate with me via email at _____ (email address)

Signature _____

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

Returning Phone Calls:

I do answer and return phone calls when I am out of the office. However, I wait until I am a private setting out of respect for your confidentiality. Typically, I am in back to back sessions during my office hours, therefore, I often return phone calls on the next business day.

Text and Email:

I am happy to adjust appointments, give you my available hours, and accept cancellations via Email and Text. This can be the most direct way to reach me. However, as stated below there is no guarantee of confidentiality with these forms of communication. Please reserve it for appointment times only. Please avoid giving any identifying information about yourself or your family.

Appointment reminders:

You can opt to receive appointment reminders the day before your appointment. Appointment information is considered "Protected Health Information" under HIPAA. In signing below, I am waiving my right to keep this information completely private, and requested that reminders be handled as noted below.

I authorize text reminders the day before appointments

Text reminders are a convenience, not a requirement. If you do not receive a reminder you are still responsible for making the appointment as scheduled.

Use the following number _____ Initial _____

More on Confidentiality:

In working with adolescents, though legally the parent(s) or legal guardian(s) of child, adolescents are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a adolescent's therapy, **I honor what the adolescents 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.** Due to the importance of trust between client and therapist, when the client is a minor I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. I will immediately inform you of life threatening issues. If risky or dangerous behaviors are a concern, I will encourage the child to disclose that information themselves, either outside of therapy meetings or during the sessions, whichever they feel more comfortable doing. I encourage you to contact me as needed with any updates or concerns that you may have. Please note that if you do this, I may advise your child that you contacted me with an update and possible concern. Please remember that texts and emails are not guaranteed confidential. You may wish to use your child's initials in any texts or emails to me.

Please initial your understanding of this here _____

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. If you insist that it remain a secret, referrals will be provided and our work together will be terminated.

Informed Consent for the Inclusion of Animal Assisted Therapy in Counseling

Animal assisted therapy is a research based intervention used with some clients. As defined by Pet Partners, Inc., Animal Assisted Therapy (AAT) is a goal-directed intervention delivered by a human service professional with specialized expertise. AAT is designed to promote improvement in human physical, social, emotional, and/or cognitive functioning.

My dog, Bella, has been a registered emotional support dog. She is a labradoodle that I have owned since she was 12 weeks old. Her temperament is perfect for the work that we do and many clients enjoy her calm, mild-mannered presence.

Considerable steps have been taken to minimize potential risks associated with human-animal interaction. But of course there are always risks when working with any animal such as allergic reactions, damage to clothing, and minor scratches or bruising. Under extremely unusual circumstances such as if the animal feels threatened or fearful, barking/growling or bites could occur. To minimize any risk, I will be fully present within the interactions instructing clients on how to best interact with Bella.

Animal Assisted Therapy is only one tool that I use as a therapist. There will be times that she is not the focus of the session depending upon the client's presenting issues and needs.

I am aware that not all clients are animal lovers and some may not be comfortable with Animal Assisted Therapy. **Please discuss with me in advance if you would like to have Bella present for a session, as depending on my schedule, she is not with me every workday.**

I have read and understand the potential benefits and risks associated with Animal Assisted Therapy and I consent to have the therapy animal present during sessions.

Printed Name

Signature

Date

Social Media Policy:

Individual therapists at Marietta Counseling do not connect with clients on social media sites. This is to protect your confidentiality and the integrity of the therapist/client relationship. Marietta Counseling and Amanda Marks, LPC, RYT maintains a social media presence on some platforms. You should be aware that if you "like" or "follow" us on social media sites others may assume you are a client of Marietta Counseling.

Telemental Mental Health Services:

These services are held on a case by case basis and at the discretion of the therapist. Online services will be held through phone, FaceTime, or VSee, a free online service that allows users to make free online phone and video calls. VSee also provides the ability to send and receive therapy registration paperwork quickly, easily, and securely - no faxing or emailing documents necessary. Simply download the VSee service to your computer through the easy steps; once connected, your session will proceed in the same manner as a face-to-face office visit.

It is important to remember that while we will work to protect your confidentiality as much as possible, VSee cannot guarantee complete confidentiality. Please always make sure you are in a private area where your conversation cannot be overheard. Please note that services are only for people living in the state of Georgia.

With certain situations such as suicidality or someone in an abusive relationship , it is best that those individuals seek treatment from a local licensed mental health professional or agency for a face-to-face consult as opposed to telemental health.

Divorce and Custody

****I am not a custody evaluator and cannot 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 your 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 all my clients waive the 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). 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 the right to have me subpoenaed and agreeing 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 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 \$135/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 \$135 per hour.

I understand these policies and hereby waive any and all rights to subpoena Amanda Marks, LPC and the clinical record on any current or future legal proceedings.

Printed Name _____

Signature _____

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 \$135 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

Initial intake appointments are 60-90 minutes and Individual counseling sessions are 50-60 minutes. Couple sessions are 60- 90 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 MCCA. MCCA does accept Master Card, American Express, Visa and Discover, in addition to cash and checks and HSA.

I am not on insurance panels; however, 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.**

Reduced fees 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 approved.

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.

Standard Fees:

Initial Intake Session: \$135.00

All other Sessions: \$135.00

Phone or Email Communications initiated by client exceeding ten minutes will be pro- rated and billed at the relevant session rate.

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

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. Please complete this form in its entirety, including a credit card to be kept securely on file!!!

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 \$135 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 _____ for any missed appointments**

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 _____

INTAKE FORM

Please provide the following information and answer the questions below. Please fill out this form and bring it to your first session.

Please note: information you provide here is protected as confidential information.

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____

Age: _____ Gender: Male Female

Marital Status: Never Married Domestic Partnership Married Separated

Divorced Widowed

Please list any children/age:

Please list anyone you reside with:

A d d r e s s :

(Street and Number)

(City, State, Zip Code)

Home Phone: (_____) May we leave a message? Yes No

Cell/Other: (_____) May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
 - Yes, previous therapist/practitioner:
-

Are you currently taking any prescription medication?

- No
- Yes

Please list:

Have you ever been prescribed psychiatric medication?

- No
- Yes

Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression?

- No
- Yes

If yes, what symptoms and for approximately how long?

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

- No
- Yes

If yes, what symptoms and when did you begin experiencing this?

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe:

8. Do you drink alcohol more than once a week? No Yes

If yes, how often _____, what type of alcohol _____

9. How often do you engage recreational drug use?

- Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes If yes, for how long?

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, maternal grandmother, paternal uncle, etc.).

Alcohol/Substance Abuse Anxiety/	yes/no
Depression	yes/no
Domestic Violence	yes/no
Eating Disorders	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no
Bipolar Disorder	yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed?

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Last grade completed in school:

3. Do you consider yourself to be spiritual or religious? No Yes
If yes, describe your faith or belief:

4. What do you consider to be some of your strengths?

5. What do you consider to be some of your weaknesses (growth areas)?

6. What would you like to accomplish out of your time in therapy?

7. Is there anything else I should know about you?
