Amy S. Robbins LPC, RPT-S
109 Anderson Street #101, Marietta, GA 30060
Phone: 706-406-3404
Fax: 404-591-7974
amyrobbinslpc@gmail.com

## INFORMED CONSENT AND AUTHORIZATION

## PLEASE READ THE FOLLOWING REGARDING MY TREATMENT POLICIES AND SIGN BELOW:

**Confidentiality:** All communication between counselor and client is held in strictest confidence unless:

A. The client authorizes release of information with a signature and waives this privilege.
B. The counselor is ordered by a court to release information.
C. Dependent abuse/neglect is suspected or revealed.
D. The client appears to pose a direct threat to his/her or someone else's life (ex. actively suicidal or homicidal).
E. Patriot Act

**Please note that it may take Amy Robbins 24-48 hours to return your call**. If an emergency, go to the emergency room of your choice or call GCAL at 1-800-715-4225.

**Regarding children:** Children (under the age of 18) are only seen with signed permission from a parent/caregiver who has legal custody of the child. Parents have a right to any and all confidential information regarding your dependent. Because the presence of trust is important in the therapeutic relationship between your dependent and us, it is generally best that we do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your dependent's treatment plan, and the progress being made toward treatment goals. If your dependent is able to understand the issue of confidentiality, we will discuss with him/her the type of information that will be shared with you. If you have objections to this manner in which information is shared with you regarding your dependent, we will need to resolve these differences before therapy begins.

**Parents/Coparents:** Parent sessions will be held on a regular basis with both parents (and/or step-parents, caregivers) to review the progress made by your child in therapy and to discuss any concerns, parenting strategies, etc.

Whenever a verbal update is provided by the therapist (to the parent that brought the child to therapy), it is that parent's responsibility to update the other parent. Co-parenting is always encouraged.

Parents are encouraged to contact therapist (as needed) to provide any updates or information that they feel will be useful for the therapy sessions. All emails will be replied to BOTH parents who have legal custody so that all communication is shared.

**Court testimony:** We are not trained in matters that involve the legal system. If required to testify for court, speak with legal counsel, etc. our fee is $200.00 an hour plus mileage and expenses incurred. We will not testify in divorce custody or mediation**. A two hour minimum is charged.**

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**Clinical Policy-** Individuals may contact their respective therapist using technological resources. In doing so, they agree to the understanding that cell phone, text, email and fax communication are **not secure nor are guaranteed confidential** methods of communication. When used, the client is, by choice, relinquishing their rights to confidentiality. Please be mindful that should you send an email to your therapist, we will review your email at the beginning of the next session. Email for Amy Robbins LPC is amyrobbinslpc@gmail.com.

Texting is allowed for scheduling or rescheduling appointments; no clinical dialogue will be shared via text. You may text 706-406-3404. If a clinical emergency, please contact 911.

There will be no therapist- client contact via social media (Facebook, Instagram, etc).

Phone consults are billed at the $125 an hour rate, in 15 minute increments.

**Therapy Treatment:** We expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. We will try to make our professional relationship one where you will receive the maximum benefit. We will also keep you informed about alternatives to therapy. Therapy may be tremendously beneficial for some individuals. At the same time, there are no guarantees for therapeutic treatment and there are some risks. These risks may include recalling unpleasant events, facing unpleasant thoughts or beliefs, increased awareness of feelings and/or alteration of your ability or desire to deal effectively with others in a relationship. In therapy, major life decisions are sometimes made. As your therapist, we will be available to discuss any of your assumptions, problems or possible negative side effects of our work together. Therapy is best if consistently attended. Please know if more than 90 days has passed since your last therapy appointment, there is no guarantee that another therapy session will be available.

**Please provide a person (other than yourself) to contact in case of emergency and a contact number here:**

**Emergency Contact:_____Phone #:_____**

**Please sign to consent to contacting this person _____**

**Termination of therapy:** Termination of therapy may occur at any time and may be initiated by you as the client or by the therapist. In either event, a final termination session is strongly recommended to explore the termination process itself. This can provide a constructive and useful conclusion to treatment. Referrals or other suggestions will be offered at that time.

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**Fees, Charges, and Responsibility for Payment:** Sessions are 45-60 minutes in length. My fee is $125.00 an hour; please pay in full by cash, check or credit card after each session, unless arrangements have been made with your insurance company. It is the client's responsibility to obtain any necessary authorizations for use of insurance. If your insurance should change within treatment, it is the client's responsibility to inform their therapist and obtain necessary authorizations, failure to do will result in client paying any balance due.

Any insurance co-pays are due at the time of service. As the insured, I am responsible for paying any co-pays dues on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner as well as any deductibles that have to be met. If you are using insurance, please note that a diagnosis will have to be provided to your insurance provider in order to submit the claim for payment.

All phone/email contact outside of session will be billed at an hourly rate of $125 in increments of 15 minutes. A fee of $25 plus additional expenses incurred will be applied should your check be returned. You will also be responsible for any expenses incurred to collect unresolved balances as well as 25% additional fee.

**Contact Procedures**: You can reach your therapist at 706-406-3404 and leave a voicemail. If an emergency or outside of office hours, go to the emergency room of your choice.

You will be responsible for payment ($75) if less than 24 hours notice is given. Insurance does not cover missed sessions.

**Forms, Letters and affidavits** will incur a $25 per report fee.

There will be no recording of sessions.

**By signing below, I attest that I understand that my therapist will do all that is necessary to file insurance benefits on my behalf and I authorize the release of any PHI as necessary to complete the insurance billing process.**

**I have read and understand the conditions as stated above and I have reviewed the updated 2013 Hippa guidelines. By signing below, I authorize my therapist to begin therapeutic treatment at this time.**

**Client Signature:**_____**Date:**_____

**Therapist Signature:**_____**Date:**_____