

Robin Day, LPC

Acceptance & Change, Inc.

490 Sun Valley Dr. Ste. 205 Roswell, GA 30076 6111 Peachtree Dunwoody Rd. Ste. F-103 Atlanta, GA 30328
404-63607435 fax: 770-642-4239

Client Information Form

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

- May I have your permission to thank this person for the referral?

Yes No

- If referred by another clinician, would you like for us to communicate with one another?

Yes No

Person(s) to notify in case of any emergency: _____

Name

Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Briefly Describe Your Current Concerns/Difficulties _____

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How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _____

Previous Hospitalizations: (Approximate dates and reasons): _____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are you parent's still married or did they divorce? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

RELATIONSHIP STATUS:

POOR
EXCELLENT

Currently in Relationship? _____ How Long? _____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships _____

Do you have children? _____ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

LEGAL STATUS:

Please describe any current legal problems/difficulties _____

Will you need confirmation of receiving therapy services for lawyer, probation officer, etc. YES NO

COPING SKILLS & SUPPORT: Briefly deescribe healthy activities which make you feel better and people with whom you can talk with when you feel down. (eg: reading, walking pets, al-anon, talking with sister, etc.)

Please complete the below to indicate current and past difficulties. Check if “yes” and leave blank if “no.” If you do not understand what I am asking for, please write in a “?” or otherwise indicate not understanding.

| | Current | In the Past/ History of | If applicable, approximate date of last time or episode |
|--|---------|----------------------------|---|
| Anxiety: | ----- | ----- | ----- |
| Excessive worry | | | |
| Social phobia or shyness | | | |
| Panic attacks | | | |
| Fear of leaving home | | | |
| Anger: | ----- | ----- | ----- |
| Irritability | | | |
| Verbal rage outbursts | | | |
| Destruction of property | | | |
| Violence towards others | | | |
| Shame: | ----- | ----- | ----- |
| Negative self-statements | | | |
| Excessive shame | | | |
| Attention Deficit: | ----- | ----- | ----- |
| Inability to stay focused on a task | | | |
| Safety: | ----- | ----- | ----- |
| Suicidal thoughts | | | |
| Suicide plan | | | |
| Suicide attempt(s) | | | |
| Self-harm | | | |
| In physically or sexually abusive relationship | | | |
| Thoughts of hurting others | | | |
| Hearing voices to harm self or other(s) | | | |
| Posttraumatic Stress: | ----- | ----- | ----- |
| History of sexual abuse in childhood | | | |
| History of physical abuse in childhood | | | |
| History of emotional abuse in childhood | | | |
| Victim of physical assault as an adult or adolescent | | | |
| Victim of rape as an adult or adolescent | | | |
| Victim of natural disaster or other trauma | | | |
| Dissociation: | ----- | ----- | ----- |
| Losing track in conversations | | | |
| Blackouts or memory loss (without drugs or alcohol) | | | |
| Flashbacks / intrusive memories of past trauma | | | |
| Having “parts” or “alters” | | | |
| Frequently losing track of time | | | |
| Fragmented or disjointed memories of childhood after age 6 | | | |
| Auditory hallucinations | | | |
| Substance Abuse | ----- | ----- | ----- |
| Binge drinking | | | |
| Alcohol abuse | | | |
| Alcohol dependence | | | |
| Drug abuse | | | |
| Drug dependence | | | |
| Eating Problems: | ----- | ----- | ----- |
| Overeating or binge eating | | | |
| Under eating | | | |
| Over exercising | | | |
| Induced vomiting | | | |
| Abuse of laxatives | | | |
| Sleeping Problems: | ----- | ----- | ----- |
| Sleeping too much | | | |
| Staying in bed all day | | | |
| Insomnia | | | |
| Frequent nightmares | | | |
| Sleepwalking | | | |

3. To Obtain Payment for Treatment: Robin Day, LPC and Acceptance & Change, Inc. may use and disclose your PHI to bill and collect payment for the treatment and services Robin Day, LPC and Acceptance & Change, Inc. provided you. Example: Robin Day, LPC and Acceptance & Change, Inc. might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. Robin Day, LPC and Acceptance & Change, Inc. could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for Robin Day, LPC and Acceptance & Change's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, Robin Day, LPC and Acceptance & Change, Inc. will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to Robin Day, LPC and Acceptance & Change, Inc. by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, Robin Day, LPC and Acceptance & Change, Inc. will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of Robin Day, LPC and Acceptance & Change, Inc.

Note: Georgia and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV**, and may limit whether and how Robin Day, LPC and Acceptance & Change, Inc. may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – Robin Day, LPC and Acceptance & Change, Inc. may use and/or disclose your PHI without your consent or authorization for the following reasons:

- 1. Law Enforcement:** Subject to certain conditions, Robin Day, LPC and Acceptance & Change, Inc. may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Robin Day, LPC and Acceptance & Change, Inc. may make a disclosure to the appropriate officials when a law requires Robin Day, LPC and Acceptance & Change, Inc. to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- 2. Lawsuits and Disputes:** Robin Day, LPC and Acceptance & Change, Inc. may disclose information about you to respond to a court or administrative order or a search warrant. Robin Day, LPC and Acceptance & Change, Inc. may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. Robin Day, LPC and Acceptance & Change, Inc. will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
- 3. Public Health Risks:** Robin Day, LPC and Acceptance & Change, Inc. may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
- 4. Food and Drug Administration (FDA):** Robin Day, LPC and Acceptance & Change, Inc. may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- 5. Serious Threat to Health or Safety:** Robin Day, LPC and Acceptance & Change, Inc. may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if Robin Day, LPC and Acceptance & Change, Inc. determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, Robin Day, LPC and Acceptance & Change, Inc. may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
- 6. Minors:** If you are a minor (under 18 years of age), Robin Day, LPC and Acceptance & Change, Inc. may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
- 7. Abuse and Neglect:** Robin Day, LPC and Acceptance & Change, Inc. may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If Robin Day, LPC and Acceptance & Change, Inc. has a reasonable suspicion of child abuse or neglect, Robin Day, LPC and Acceptance & Change, Inc. will report this to the Georgia Department of Child and Family Services.
- 8. Coroners, Medical Examiners, and Funeral Directors:** Robin Day, LPC and Acceptance & Change, Inc. may

release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. Robin Day, LPC and Acceptance & Change, Inc. may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

9. **Communications with Family, Friends, or Others:** Robin Day, LPC and Acceptance & Change, Inc. may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, Robin Day, LPC and Acceptance & Change, Inc. may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, Robin Day, LPC and Acceptance & Change, Inc. may release PHI about you as required by military command authorities. Robin Day, LPC and Acceptance & Change, Inc. may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** Robin Day, LPC and Acceptance & Change, Inc. may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, Robin Day, LPC and Acceptance & Change, Inc. may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, Robin Day, LPC and Acceptance & Change, Inc. may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:**
Robin Day, LPC and Acceptance & Change, Inc. may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** Robin Day, LPC and Acceptance & Change, Inc. is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** Robin Day, LPC and Acceptance & Change, Inc. may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess Robin Day, LPC and Acceptance & Change, Inc.'s compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, Robin Day, LPC and Acceptance & Change, Inc. will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying Robin Day, LPC and Acceptance & Change, Inc. in writing of your decision. You understand that Robin Day, LPC and Acceptance & Change, Inc. is unable to take back any disclosures it has already made with your permission, Robin Day, LPC and Acceptance & Change, Inc. will continue to comply with laws that require certain disclosures, and Robin Day, LPC and Acceptance & Change, Inc. is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in Robin Day, LPC and Acceptance & Change, Inc.'s possession, or to get copies of it; however, you must request it in writing. If Robin Day, LPC and Acceptance & Change, Inc. does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from Robin Day, LPC and Acceptance & Change, Inc. within 30 days of receiving your written request. Under certain circumstances, Robin Day, LPC and Acceptance & Change, Inc. may feel it must deny your request, but if it does, Robin Day, LPC and Acceptance & Change, Inc. will give you, in writing, the reasons for the denial. Robin Day, LPC and Acceptance & Change, Inc. will also explain your right to have its denial reviewed.

If you ask for copies of your PHI, you will be charged not more than \$.25 per page and the fees associated with supplies and postage. Robin Day, LPC and Acceptance & Change, Inc. may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that Robin Day, LPC and Acceptance & Change, Inc. limit how it uses and discloses your PHI. While Robin Day, LPC and Acceptance & Change, Inc. will consider your request, it is not legally bound to agree. If Robin Day, LPC and Acceptance & Change, Inc. does agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that Robin Day, LPC and Acceptance & Change, Inc. is legally required or permitted to make.

3. The Right to Choose How Robin Day, LPC and Acceptance & Change, Inc. Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). Robin Day, LPC and Acceptance & Change, Inc. is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that Robin Day, LPC and Acceptance & Change, Inc. has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

Robin Day, LPC and Acceptance & Change, Inc. will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. Robin Day, LPC and Acceptance & Change, Inc. will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that Robin Day, LPC and Acceptance & Change, Inc. correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of Robin Day, LPC and Acceptance & Change, Inc.'s receipt of your request. Robin Day, LPC and Acceptance & Change, Inc. may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than Robin Day, LPC and Acceptance & Change, Inc., denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and Robin Day, LPC and Acceptance & Change, Inc.'s denial will be attached to any future disclosures of your PHI. If Robin Day, LPC and Acceptance & Change, Inc. approves your request, it will make the change(s) to your PHI. Additionally, Robin Day, LPC and Acceptance & Change, Inc. will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to Robin Day, LPC and Acceptance & Change, Inc.'s Director and Privacy Officer, Robin Day, LPC at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision Robin Day, LPC and Acceptance & Change, Inc. made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. Robin Day, LPC and Acceptance & Change, Inc. will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

**Please discuss any questions or concerns with your therapist. Your signature below indicates that you
Acknowledge receipt of this Notice:**

Client Name (please print)

Client Signature

Date

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your psychotherapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. 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 your therapeutic experience. 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

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

- In 1996 I graduated from GA State University with a Master's in Education
- From 1995 - 1997 I worked for the Henry Co. Mental Health Center with adults with dissociative disorders, borderline personality, and other serious mental illnesses.
- In 1998 I worked for Charter Peachford psychiatric hospital as a social worker.
- In 1998 – 1999 I again worked for the Henry Co. Mental Health Center, this time with adults with alcohol and substance dependence.
- In 1999 I received my licensure to practice independently in Georgia.
- In 1999 – 2002 I worked for Northside Hospital's psychosocial rehabilitation facility with persons with borderline personality, schizophrenia, and other serious mental illnesses.
- In 2002 I began my private practice. I have worked with adults and adolescents with various diagnoses and concerns.
- In 2004 I attended for one week an intensive training in Dialectical Behavior Therapy.
- In 2007 I attended 40 hours of training in EMDR.
- Throughout my career as a therapist I have attended workshops on various issues. I have also presented workshops Dialectical Behavior Therapy.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. 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. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. 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 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.

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 one of my offices or off-site. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about 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 therapist. The state of Georgia has a very good track record in 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.

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Structure and Cost of Sessions

I agree to provide psychotherapy for the fee of \$110 per 50 minute session, \$160 per 75 minute session, and/or \$35 per 90 minute group therapy session, unless otherwise negotiated by you or your insurance carrier. I also charge \$110 per hour for reports. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at \$2 per minute. The fee for each session will be due at the conclusion of the session. Cash or personal checks are acceptable for payment. I am unable to accept debit cards and credit cards. I am happy to provide receipts as requested. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. I will file for insurance reimbursement if I am an in-network provider. It is your responsibility, however, to contact my billing clerk and give her your insurance information *before* our first appointment. If I am not an in-network provider, it is your responsibility to file for reimbursement. If I am not an in-network provider for your insurance, I expect full payment at the time of service. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

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.

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 do not carry a beeper nor am I available at all times. I generally return calls made before 9:00pm in 1-2 hours. Approximately 4 weeks out of the year I am unavailable by phone. These periods of unavailability generally last 4 to 7 days. If I am seeing you every week, I will inform you verbally ahead of time when I will be temporarily unavailable. However, if I am seeing you less than once per week, you may not receive advanced notice. If I am unavailable by phone, my voicemail will indicate this, and you will be directed call the below numbers as necessary.

Please initial to indicate you have read this page _____

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. If you have a mental health emergency and I am either unavailable or do not return your call within 2 hours, or if you feel that immediate attention is needed, I encourage you to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589.
- Call 911.
- Go to your nearest emergency room.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested or well used theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

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 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 very nature of psychotherapy, 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 to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships 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 discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

It is important at times for me to be able to communicate with others in order to help you maintain safety. I generally request a release of information for your medical doctor or your psychiatrist. If you appear to be at high risk for suicide or other harmful behaviors, I may also ask for a release for a family member or friend.

Please initial to indicate you have read this page _____

Please be aware that if you appear to be at high risk for self-harm or harm to others and you revoke your releases of information for your psychiatrist or other support person, I may discontinue treatment with you. Again, I must be able to communicate with others in order to help you remain safe.

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.

THIS SECTION APPLIES ONLY TO PARTICIPANTS IN DBT SKILLS CLASSES/GROUPS

Participants in DBT skills classes/groups are required to see a therapist for individual or family therapy at least once per month. This therapist can be myself or another professional. Risk assessments and psychotherapy are not provided in these psycho-educational groups. If you discontinue treatment with your individual or family therapist, I will ask you to discontinue the DBT skills classes/groups also.

Regarding fees: Unlike other types of therapy I do charge \$35 for missed classes/groups whether or not I receive 24 hours notice for your absence. This is a "holding your space" fee. This policy is effective unless your insurance plan requires me to do otherwise.

I do not provide telephone availability for class/group participants unless I am also seeing you for other types of therapy. If you need extra help between classes/groups I encourage you to call your therapist or call 911, Peachford Hospital, or Ridgeview Hospital (see above).

THIS SECTION APPLIES ONLY TO PARTICIPANTS IN EMDR

EMDR is usually not a short-term therapy. As with all forms of therapy, your symptoms may increase before they decrease. I will make every effort to ease any discomfort that arises from EMDR. You can stop EMDR at any time during a session just by saying "stop." You can also ask to discontinue EMDR altogether. If you decide to stop EMDR altogether, we can resume regular "talk" therapy.

The process of EMDR can remove unnecessary details from trauma memory. For example, a rape victim may be unable to remember that her attacker's shirt was green. Therefore, *if you are considering legal action as a result of trauma, I strongly advise against EMDR.* In this case, we can discuss various alternative therapies, and you can consult with an attorney regarding this difficulty with EMDR.

Please print, date, and sign your name below 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 are authorizing me to begin treatment with you.

Client Name (Please Print)

Date

Client Signature

If Applicable:

Parent's or Legal Guardian's Name (Please Print)

Date

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Therapist's Signature

Date

Please initial to indicate you have read this page _____