LOTTS OF LOVE
COUNSELING

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BUSINESS POLICIES, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to LOLC/Tracey Roberson. This document contains important information about my professional services and policies. Please review it thoroughly and feel free to ask me any question that you might have.

This document is designed to inform you about what you can expect from me regarding office policies, confidentiality, emergencies, and several other details regarding your treatment. Please read them and if you have any questions, discuss them with me. Please note that when you sign this document or sign that you have received this document, it will represent an agreement between us.

Background Information

Tracey is a Licensed Professional Counselor, she is also certified in Marriage & Family Therapy and Anger Management, her office is in Decatur Georgia along with several other independent practitioners of various specialties. Tracey has 15+ years of experience working with clients of all ages from various backgrounds she has provided therapy to families, couples, teens, adolescents, and children. One of the goals of her practice is to empower clients to gain a better quality of life and personal well-being. Her counseling allows for freedom of laughter, tears, conversation, silence, and emotions. Tracey enjoys treating clients struggling with depression, grief, anxiety, anger management, and stress management. Tracy has training in dialectical behavior therapy (DBT), systematic training for effective parenting (S.T.E.P) anger management, project alert, and project Success. Through humor, transparency, and personal testimonies of challenges and triumphs, Tracey is able to effectively and efficiently reach her clients.

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.

Psychotherapy can have benefits and risks. Therapy at times, can often involve discussing unpleasant aspects of your life. This may result in you experiencing uncomfortable feelings like sadness, guilt, frustration, and anger. The important thing to remember is that psychotherapy has also been shown to have benefits for people who go through it. Therapy can lead to solutions to problems, an overall reduction in feelings of distress, and better relationships. There are no guarantees of what you will experience, however we will work together to ensure that most of your goals are met.

In order for therapy to be most successful, it is important for you to take an active role, both during and between sessions. This also means avoiding any mind-altering substances including but not limited to alcohol and 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 has 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 can face life's challenges in the future without me. I also do not 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). 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 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 to me 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 if applicable. Please note that this does not apply if you reveal to me information that might put your life at risk. If I am put in a position of being asked to keep a secret, due to ethical reasons, I may have to terminate my work with you. If any person from any party wishes to release the information found in the clinical record, I require that both parties sign the release.

Minors

If you are your child is under 18 years of age, please be aware that by law one's parents may have the right to examine a minor's treatment records. It is my policy to request an agreement from parents that they agree to give up access to their minor child's records as to encourage honesty and openness unless the minor child reports that they are in danger.

Couples

When working with couples, confidentiality still applies with a few exceptions. It is important to note that as your couple's therapist I have a "no secrets" policy. This means that I will not agree to keep any secrets between you and your partner. Please note that if I am placed in a situation in which I am asked to keep a secret, I may have to terminate working with you and refer you to another therapist. I also require that if records are to be released that both parties sign off on the release form that gives me permission to release any mutual records.

Financial Terms and Fees

Lotts of Love Counseling, LLC. Is currently accepting some insurances. All acceptable forms of payments are checks, cash, debit card or credit card. Please let me know if you have any questions and/or concerns regarding this. I do offer a variety of service packages that can be custom designed to fit your needs.

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Client's Initials

Court and Legal

It is in your best interest to know that conducting expert witness/testimonial service is not my area of expertise. I DO NOT agree to service as an expert witness or to provide testimonial services for you, your child, or any member of your family, and you agree not to cause my services to be used in this way. If you are seeking counseling for court or court related purposes or motivations, I will provide you alternative appropriate sources. For legal proceedings that require my response should you, your attorney, your spouses or ex-spouses attorney subpoena me or your client files as a factual case witness (including time spent responding to subpoenas, depositions, case preparations, travel, witness time, any time related to a court –related process, etc.) I bill $450 per hour (4-hour minimum). You agree to pay this amount, regardless of whose attorney subpoena my involvement. Client records will not be released without written consent unless court ordered to do so. You further agree to pay a retainer fee of $2400.00 at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me now before a counseling relationship is established, and appropriate referral sources will be provided to you.

Please note: 48-hour advanced notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 48-hour notification is not made, a fee of $2400.00 will be billed. (8hrs @ $450.00 per hour).

Should you or an entity through your signature request a copy of you, your spouse and your child's counseling records please be aware that a $35.00 record preparation fee will be incurred (up to 2 pages) and $35.00 per every 15 minutes thereafter. Also, a "Release of Records" form must be signed. An overall counseling summary in lieu of records may also be provided. **If records are subpoenaed this does not indicate an automatic release of records and is at liberty to be squashed should it be deemed not in the client's best interest.**

☐ I AM seeking services for court ☐ I AM NOT seeking services for court

Other Service Fees:

Paperwork charges for disability evaluations, court ordered evaluations, completion of forms for attorneys or employers, or any other type of reports requested by you or an outside source is $50.00 for complex and simple work.

If a check is returned, there will be a $35.00 return check fee charged.

Court appearance charges start at $450.00 and increase depending on time spent in court and client scheduling time lost. You also agree to pay a $2400.00 retainer fee at the time a subpoena is served to be applied towards these charges.

There is a charge of $35.00 to copy records, plus postage if applicable.

Cancellation/Missed Appointments Policy

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Client's Initials

Each session is approximately **30-55** minutes in length. Your appointment time is reserved especially for you. Please respect that there may be times when other clients are on a waiting list to be seen. **If you must cancel, please notify the office as soon as possible. If an appointment is missed or it is cancelled with less than 24 hours notice, you may be charged $50.00.**

In Case of an Emergency

I am available to return routine and urgent calls within 24 business hours. Please note that I am often not immediately available by telephone. It is my policy to not answer my phone if I am with a client. When I am unavailable, my voice mail will be available for you to leave a message. If emergency mental health services are needed and I am not available to contact you immediately, call the emergency mental health number in your county (**Behavior Health Link-1-800-715-4225**), or go directly to the nearest emergency room or call 911.

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 (e.g., social, business, etc.), we would then have a "dual relationship." Dual relationships may compromise our treatment and, therefore, are discouraged in the mental health profession. To offer all my clients the best care, my judgment needs to be unselfish and purely focused on your needs. Therefore, 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 theories and methods of change.

You should also know that therapists are required to keep the identity of their client's 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.

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Client's Initials

Termination Policy

People terminate counseling for various reasons. Sometimes termination is premature of goals being met, while at times counseling is terminated because goals have been accomplished. I want to ensure you that it is my policy to support all termination, for whatever reason.

Termination (ending therapy) is an important part of the treatment process. It is best this be a joint decision so progress can be reviewed and expectations for the future can be discussed. Although it is my goal to work with you until your treatment goals have been completed, there will be times when therapy will have to be terminated prematurely. If I cannot provide appropriate therapy for your treatment needs, if treatment goals that are mutually agreeable cannot be developed, if financial commitments are not honored, if you are not benefiting from therapy or if the therapy environment becomes unsafe, if there is repeated non-compliance with appointments, the therapeutic relationship will be terminated.

Any non-voluntary termination will be accompanied by an appropriate referral for mental health services. A case will be identified as voluntarily closed after mutual discussion between therapist and client(s) or if there has been no contact for 60 days.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me to maintain your confidentiality, respect your boundaries, and ascertain that our relationship remains therapeutic and professional. Therefore, I have developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for me not to use a cell phone when contacting you, please let me know.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.

Facebook, LinkedIn, Etc: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook or LinkedIn because it may compromise your confidentiality. Additionally, my ethics code prevents me from soliciting endorsements from clients, and the concept of "Fanning" is considered to be bordering on such solicitation. However, it is still your prerogative to view or share any content on my professional pages. Please note that you should be able to subscribe to my professional Facebook page via Really Simple Syndication (RSS) without becoming a Fan and without creating a visible, public link to my Page, which I strongly encourage for your privacy.

Google: I do not search for clients on Google. I respect your privacy and make it a policy to allow you to share information about yourself to me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: I sometimes post psychology news on Twitter, and I write a blog on my website. If you have an interest in following either of these, please let me know so that we may discuss any potential implications to

our therapeutic relationship. Once again, maintaining your confidentiality is a priority. I would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to my content.

In summary, technology is constantly changing, and there are implications to all the above that I may not realize at this time. Please feel free to ask questions and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Information, Authorization, & Consent to Telemental Health Counseling

This section is dedicated specifically for Telemental Health counseling in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Telemental Health. Telemental Health includes email, phone, electronic chat and video counseling. Prior to engage in Telemental Health counseling an assessment/consultation will be done to assure that Telemental Health counseling is an appropriate form of counseling for you. This is to inform you about what you can expect regarding your participation in Telemental Health counseling.

Benefits:

The benefits of Telemental Health counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

Limitations:

It is important to note that there are limitations to Telemental Health Counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the telemental health counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.
6. To reduce the effect of these limitations, I will also ask that you show your face and as much of your body as possible. Depending of the nature of the session, I may ask that you pan the room with your camera.

Safety Measures and Precaution:

It is important that safety and confidentiality is the always a priority. The following safety measures and precautions will be put in place while facilitating telemental health counseling for your protection and confidentiality:

1. I must be able to see your face, as much of your body and background as possible. “You may be asked to pan the room with your camera”.
2. An assessment will be done to ensure that you are an appropriate candidate for telemental health counseling.
3. A code-word or a number(s) will be established to minimize the breach of confidentiality and or safety. The code will/can be used when:

a. Your health, safety and or confidentiality is being compromised
b. Someone has entered the room or space where we are having a confidential session
c. You are not able to speak freely
d. You don't feel safe
e. Someone is attempting to watch and or listen to our confidential session
f. You have been threatened to do or say something against your will
g. You are requesting information by force

Logistics: When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused, and engaged in the session. I am calling you from a private location where I am the only person in the room.

You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call me at 678 674 6755 if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you **2** times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Please list your main number and an alternate number below.

_____

Number(s)

Recording of Sessions:
Please note that recording, screenshots, etc. of any kind of any session is **not permitted** and are grounds for termination of the client-therapist relationship.

Payment for Services:
Payments for services must be made **prior** to each session. I will charge your card and or accept other forms

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Client's Initials

of payment before the session. Payment is to be completed prior to our session.

Cancellation Policy:
If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged $50.00 for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If clients have more than 2 cancellations during the course of treatment/therapy the therapist and client will address the need for ongoing therapy. Should a client express and wish and/or desire to continue a client may be asked to pre-pay for sessions when they are scheduled. If the client cancels or misses the session with less than 24-hours notice and the session is pre-paid, this follows the cancelation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours.

Phone/video sessions should be and will be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality Contact Person:
There are additional procedures that we need to have in place specific for Telemental Health counseling. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telemental Health counseling is not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to contact you via telephone and go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.
- You agree to inform me of the address where you are at the beginning of every Telemental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Telemental Health session). Please list this hospital and contact number here:
  Hospital: _____ Phone: _____

I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____
Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____
Street Address

_____
City State Zip Code

_____
City and State of Local Police Department Phone Number

_____
Client's Initials

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to

1. Call 911
2. Call Behavioral health Link 1800.715.4225
3. Call Ridgeview Institute at 770.434.4567 or local hospital
4. Call Peachford Hospital at 770.454.5589 or local hospital
5. Call National Suicide Hotline at 1800.784.2433
6. Call Lifeline/National Crisis Line at 1800.273.9255
7. Go to emergency room of your choice

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Statement Regarding Ethics, Client Welfare & Safety

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.

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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.

By signing below, you agree that you have read and understand all of the above sections of this inform consent to include the Telemental Health Counseling informed consent section. You agree that you also understand the limitations associated with participating in telemental health counseling sessions and consent to attend sessions under the terms described in this document.

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form as well as the "Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

_____

Client's Initials

If Applicable:

_____ _____
Parent's or Legal Guardian's Name (Please Print) **Date**

_____
Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Therapist's Name **Date**

Statement Regarding Ethics, Client Welfare & Safety

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_____ _____
Client Name (Please Print) **Date**

_____
Client Signature

If Applicable:

_____ _____
Parent's or Legal Guardian's Name (Please Print) **Date**

_____
Client's Initials

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Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Name **Date**

_____

Client's Initials