

**AnneMarie Jeffries, PsyD**  
Licensed Psychologist  
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**INFORMATION, AUTHORIZATION, AND  
CONSENT TO TREATMENT**

This agreement is between \_\_\_\_\_ (client) and AnneMarie Jeffries, PsyD (psychologist) located at 1409 North Highland Avenue.

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have, so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES**

Psychological services are varied and may include consultation, assessment/evaluation, and treatment. Psychological services vary depending on the personalities of the therapist and client, and the particular issues you bring forward. Psychological services are not guaranteed to be successful, nor is there a guarantee of what you will experience. Also, these services can have benefits and risks, which you and I can discuss in our initial meeting and as it comes up throughout the course of our work together. The outcome of psychological services usually involves collaboration between us.

**MEETINGS**

**Initial Evaluation (90 minutes):** The aim of the initial session is to give you a chance to tell me about your presenting concerns and what you hope to get from therapy. It also is meant to help me get a better sense of what you want and need from our work together,

and to help us both decide if I am the best person to provide the services you need in order to meet your treatment goals.

**Psychotherapy hour (50 minutes):** If you decide to engage in psychotherapy with me, I offer 50-minute sessions. We can decide the frequency of your visits according to your needs, and together we will reevaluate your needs on an ongoing basis throughout our work together.

If, at any time we decide not to work together, I am happy to assist you with information for referrals and additional resources.

**Cancellation:** Once an appointment is scheduled, you will be expected to pay for it unless you provide me with **at least 48 hours advance notice of cancellation**. It is important to note that insurance companies do not cover costs for appointments not attended, so you likely will be solely responsible for the charge for cancelled/missed appointments where you did not provide at least 48 hours notice.

### **PROFESSIONAL FEES**

The cost for a 90-minute initial assessment is **\$250.00**, and my hourly fee is **\$175.00** for a 50-minute psychotherapy hour. In addition to weekly appointments, I charge this amount per hour for other professional services you may need. Other services include report writing, attendance at meetings with other professionals you have authorized for purposes of your treatment, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

I am open to discussing fees and payment options with you, so that we can come to a comfortable agreement for us both (please see Fees and Payment form).

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If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

Because of the difficulty of legal involvement, I charge \$300.00 per hour for preparation and attendance at any legal proceeding, and this is charged in four-hour increments.

### **BILLING AND PAYMENTS**

The fee for each session is due at the time it is held, unless we agree otherwise. I accepted payments in the form of cash, check, or credit card (Visa, Mastercard, Discover, American Express). Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

### **INSURANCE REIMBURSEMENT**

At this time, I accept **out-of-network insurance benefits**. If you plan to use insurance benefits to help with the cost of therapy, it is very important that you find out exactly what mental health services your insurance policy covers. I will provide you with an invoice ("super bill") that you can submit to your insurance company for reimbursement. I am happy to assist you in the process of insurance coverage for my services; however, you (not your insurance company) are responsible for full payment of my fees.

### **CONTACTING ME**

The hours I am in the office vary, and I typically do not answer the phone when I am with a client. When I am unavailable, please leave me a voicemail, and I will return your call as soon as I can. If I will be unavailable for an extended time, I will provide you with the name of a trusted colleague whom you may contact if necessary.

### **IN CASE OF AN EMERGENCY**

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I do not provide emergency services. If you experience an **emergency** or if you are unable to reach me and feel that you cannot wait for me to return your call, I encourage you to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep a clinical record of treatment, which is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with TherapyNotes, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, Federally approved encryption. Additionally, your PHI will be kept in a file stored in a locked cabinet in my home office.

You are entitled to examine and/or receive a copy of your records if you request it in writing except in certain circumstances that involve: 1) danger to yourself and/or others, 2) where records make reference to another person (unless such person is a healthcare provider) and I believe that access to records is reasonably likely to cause substantial harm to such person, 3) where information has been provided to me by confidential others. Because these are professional records, they can be misinterpreted

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and/or upsetting to untrained readers. For this reason, if you wish to see your records, I recommend that you review them in my presence or have me forward your records to another mental health professional so you can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

### **CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY**

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission (signed Release of Information). However, there are a few important exceptions to this, where I am permitted or required to disclose information without either your consent or authorization. These situations are as follows:

- 1) In most legal proceedings, you have the right to prevent me from providing any information about your treatment. However, in some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
- 2) If a government agency requests information for health oversight activities, I may be required to provide it to them.
- 3) If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- 4) If a client files a worker's compensation claim and I am providing treatment related to that claim, I must upon request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment:

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- 1) If I have reason to believe that a child has been abused, I am required to file a report with the appropriate state agency. Once such a report is filed, I may be required to provide additional information. In addition, the Georgia Child

Endangerment Law requires that I report to the appropriate governmental agency if I am made aware of a child witnessing acts of violence between adults.

- 2) If I have reasonable cause to believe that a disabled adult or an elderly person (over 65 years of age) has had a physical injury inflicted upon him/her other than by accidental means or has been neglected or exploited, I am required to report this to the appropriate agencies. Once such a report is filed, I may be required to provide additional information.
- 3) If I determine that a client presents a serious danger of physical harm to another, I may be required to take protective actions. These protective actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- 4) If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If one of these situations occurs, I will make every effort to fully discuss it with you before taking any action.

There are other situations that require that you provide only written, advanced consent. Your signature at the bottom of this form provides consent for these activities as follows:

- 1) I may find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important to our work together. I will document consultations in your clinical record.
- 2) Disclosure required by health insurers or to collect overdue fees are discussed in the Georgia Notice Form.

Please initial that you have read this page \_\_\_\_\_

- 3) I currently do not employ administrative staff. If this situation changes, I will notify you in writing with a revised consent form.

While I hope that this written summary is helpful in informing you about confidentiality and limits to confidentiality in the client-psychologist relationship, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you further.

**REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION** All reasonable requests to receive communication of your health information will be granted (i.e., telephone, mail). If you wish to receive protected health information in one particular manner, please indicate that to me in writing. Otherwise, I will leave messages at the phone numbers you provide and send mail to the mailing address you have indicated. Your signature below indicates that I may notify you at any of the phone numbers and/or addresses that you have provided.

#### **PATIENT RIGHTS**

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include the following: 1) requesting that I amend your record, 2) requesting restrictions on what information from your Clinical Record is disclosed to others, 3) requesting an account of most disclosures of protected health information, 4) determining the location to which protected information disclosures are sent, 5) having any complaints you make about my policies and procedures recorded in your records, and 6) the right to a paper copy of this Agreement, the attached Georgia Notice form, and my privacy policies and procedures.

#### **MINORS AND PARENTS**

Clients under eighteen years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I believe that doing so would endanger the child, or if we agree otherwise. Because privacy

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in psychological services is often crucial to successful progress, it is my policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, during treatment, I will provide parents only with general information about the progress of their child's treatment as well as attendance at scheduled sessions. Upon request, I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger of harming oneself or someone else. In that case, I will notify parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and will do my best to handle any objections he or she may have.

### **PROFESSIONAL RELATIONSHIP**

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, our relationship 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 way, we 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.

It is also important for you to know that therapists are required to keep the identity of their clients confidential. For your confidentiality, I will not address you in public unless you speak to me first. I must also 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 ethical duty as a therapist to always maintain a professional role.

### **STATEMENT REGARDING ETHICS, CLIENT WELFARE AND SAFETY**

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological 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

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immediately. If we are unable to resolve your concern, I will provide you with information to contact the 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 is not 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.

### **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 that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. I realize that many people

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prefer to text and/or email because it is a quick way to convey information. **However, please know that it is my policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy).** Therefore, please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that I will not respond. **You also need to know that I am required to keep a summary or copy of all emails and texts as part of your clinical record that address anything related to therapy.**

Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc: It is my policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter Direct Message. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Faxing Medical Records:

If you authorize me (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, I may need to fax that information to the authorized entity. It is my responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of my fax machine.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and

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communicate to me if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations.

In summary, technology is constantly changing, and there are implications to all of the above that we 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.

**OUR AGREEMENT TO ENTER INTO A THERAPEUTIC RELATIONSHIP**

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 me. Please print, date, and sign your name. Your signature below indicates that you have read and understand the information in this **Information, Authorization, and Consent to Treatment** form and agree to abide by its terms. Your signature below also indicates that you have received and understand the **Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices**” provided to you separately. Lastly, your signature indicates that you are authorizing me to begin treatment with you.

Print name- Client

Print name- Parent /Legal Guardian

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Signature- Client

Signature- Parent /Legal Guardian

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Date

Psychologist

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