Client(s) name: _____

Micah Counseling Services

Counseling – Coaching – Consulting

Information, Disclosure and Consent Form

Welcome. Micah Counseling services welcomes you as a potential client. It is our policy to inform you about the nature of counseling and psychotherapy, the policies and procedure concerning the help you will receive at this center, the fees charged for our services and your rights and responsibilities as a client. At the end of this form, there will be a place for your signature signifying your general consent to therapy.

Counseling and Psychotherapy. The words counseling, psychotherapy and therapy are generally used interchangeably to indicate forms of treatment and intervention that seek to address a range of personal and family distress such as depression, anxiety, challenges adjusting to difficulties at work or with other people as well as martial conflicts and problems. The goals of therapy can range from relief of symptoms related to significant life transitions to personality changes based on gaining a better understanding of one's personal, interpersonal, and social circumstances and resources.

Micah Counseling Services methods of treatment are based upon standard practices common to the training and experience of psychotherapists, marriage and family therapists, psychologists, social workers, and pastoral counselors. Therapy is conducted within the standards and ethical guidelines of state licensing laws and professional associations. We also respond to the spiritual, religious, and theological needs and concerns of clients whom these values make a difference in the process of change and growth as well as desire these factors to be considered in treatment.

Therapy Process

Therapy begins with an intake and assessment process that is intended to evaluate your needs and concerns and to help you and the therapist decide about engaging in therapy. This process can take one interview or may extend over several interviews. If you or the therapist comes to the determination that another provider may better serve your needs, we will assist you in getting connected to another counselor. Therapy may take many forms depending upon your issues and needs and how far you wish to go in addressing them. This process is guided by a treatment plan that you and the therapist agree to pursue. Therapy ends when the goal(s) have been met, or at a point you decide to end therapy. Services are provided virtually (via Zoom) unless otherwise arranged.

Therapy Policies and Procedures

Your Rights as a Client. As a client, you have all the rights established by the state of Georgia governing clinical practices. These include the right to consent to treatment, seeking disclosure from your therapist about his or her qualifications, requesting a different therapist, ending therapy at any time, and having your records of treatment kept in confidence.

Confidentiality. The information you share with your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal laws or as part of the professional practice of this center. By law, there are circumstances when the therapist must report information to the appropriate persons and authorities. For example, 1) if you threaten bodily harm or death to yourself or someone else; 2) if you reveal information about child, elder, disabled, or dependent adult, or parental abuse; 3) if ordered by a court of law. If your therapy is court-ordered, the results of treatment must be revealed to the court. In all other instances, your written permission is required before your therapist or Micah Counseling Services can reveal information about your treatment as we maintain high clinical standards in our diagnosis, treatment, case records and business operations. We will protect your confidentiality.

Appointments and Cancellations. All appointments are made with your therapist. **If you are unable to maintain your scheduled appointment, please notify your therapist 24 hours in advance**. Failure to do so may result in

a charge up to the amount of your fee. This charge is not covered by insurance or EAPs. Exceptions may be made to this policy in the event of an emergency provided you notify your therapist in advance of your appointment.

Emergency Contact. Your therapist will provide you with a voicemail/contact phone number and will let you know his or her availability in an emergency. In the event of a mental health emergency in which you are not able to contact your therapist, you should call 911 or go to the nearest hospital emergency room.

Fees and Payments. Therapy sessions normally last approximately 60 minutes and the standard fee per session is: $150 - Individual; $200 - Couple; $250 - Family (up to 4 members); Individual Group Member - $80.

The fee will be discussed in the first session with the therapist. The agreed upon fee is $ _____.

Payment is due at the time of your appointment. **You may pay by cash, check, Zelle, CashApp, or credit card**. Each check returned because of insufficient funds will result in a charge to you by Micah Counseling Services of $50. If your account is more than 60 days overdue, we reserve the right to turn your account over to a collection agency. You specifically waive any right to confidentiality regarding financial information given by Micah Counseling Services to a collection agency.

Ending Therapy. You may end therapy at any time. However, it is recommended that you have at least one concluding appointment with your therapist rather than terminating by telephone, mail, or by not showing up for your appointment.

Expert Testimony. Generally, I do not attend court and provide expert testimony unless required by law. This activity is outside my clinical scope of practice.

General Consent to Treatment

Please initial the following as indicated:

___ I have seen and read the information contained in this Information, Disclosure and Consent Form.
___ I have seen and/or been offered a copy of Micah Counseling Services confidentiality policy practices as mandated by the *Health Information Portability and Accountability Act* (HIPAA).
___ I consent to treatment as described in this form.
___ I will pay for my therapy expenses as described above.

Client Signature(s)

_____ Date: _____

_____ Date: _____

Parent or Legal Guardian of a Minor

_____ Date: _____

Revised 9/12/2023.