MOSAIC COUNSELING GROUP
INFORMED CONSENT & POLICY AND PROCEDURES FOR THERAPY SERVICES

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to Mosaic Counseling Group, LLC. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you and your therapist. You and your therapist can discuss any questions you have when you sign them or at any time in the future.

THERAPY SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. My professional responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever

they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

PROFESSIONAL RECORDS

I am required to keep records of the professional services I provide [your treatment and our work together.] Because these records contain information that can be misunderstood by someone who is not a mental health professional, I am willing to review your records with you or provide a treatment summary at your request.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. 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.

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. For example, if I believe that a child, elderly person, or disabled person is being abused, I may be required to file a report with the Division of Family and Children Services.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may recommend that they seek hospitalization for him/her or to contact family members or others who can help provide protection. If these situations occur I will make every effort to fully discuss it with you before taking any action.

Providers at Mosaic Counseling Group holding an associate license (LAPC, LMSW, LAMFT) work under the direction of Ann Shannon, LCSW, RPT-S. All providers attend periodic supervision and case consultation with other licensed professionals where the progress of selected clients is discussed. Professional standards of confidentially apply.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent to me via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so but only with documented consent. While I try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

I am ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply.

SOCIAL MEDIA

Mosaic Counseling Group has a variety of social media accounts. This is intended to be informational for the public and provide helpful topics and posts about our practice, therapy, art, or expressive therapy information. Please be aware that if you choose to follow Mosaic Counseling Group on any form of social media there may be identifiable information about you visible to the public. I only follow other health professionals and I do not follow current or former clients. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy session.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. If you miss your appointment without giving notice it is your responsibility to contact our office to reschedule. If you do not contact our office to confirm your next appointment within 24 hours of your missed appointment you may be removed from the schedule. We may not be able to continue scheduling your sessions after two or more missed appointments without 24 hours' notice. This will be determined on a case by case basis. You may also be responsible for a missed session fee of $35.00 depending upon your insurance provider's policy. The missed session fee is due prior to attending your next scheduled session.

PROFESSIONAL FEES/ INSURANCE

Please refer to our fee/rate sheet for your payment responsibility. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by credit/debit card, check or cash. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur.

If one of our therapists is subpoenaed for court the fee is $100.00 per hour with a 2-hour minimum. A $200.00 deposit is required prior to the date of the hearing. Standard travel rates will be charged for court appearances outside of Gwinnett County. Additional fees that are accrued will be billed and payment will be required upon receipt of invoice.

It is my practice to charge $60.00 per hour for other professional correspondence that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations, which you have requested. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

-For those with insurance/Medicaid benefits - I will file claims with those agencies. Please be aware in order to bill for mental health services a diagnosis from the current version of the Diagnostic and Statistical Manual (DSM) is required. Please ask for clarification if you do not know what this entails.

*If your insurance/Medicaid benefits expire or become inactive and you and/or your child attend a session without the notifying therapist -- payment of you and/or your child's typical reimbursement amount will be owed. I am willing to work with clients on a case by case basis to continue child's therapy when discussed prior to session.

CONTACTING ME

Mosaic Counseling Group, LLC's contact number is: (770) 597-1647. I can also be contacted via email at (*Therapist first name*)@mosaiccounselinggroup.com. I am often not immediately available by telephone. Most often our Practice Manager, Zach Johnston, will be answering the phone. You may leave a message with him or on our voicemail. Your call or email will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, you might consider 1) contacting Ridgeview Hospital or Summit Ridge Hospital 2) going to your Local Hospital Emergency Room, or 3) calling 911 and ask to speak to the mental health worker on call.

I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LEGAL ISSUES:

If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order.

*I AM AWARE THAT THE LAW REQUIRES MY THERAPIST TO REPORT SUSPECTED CHILD ABUSE OR NEGLECT TO THE DEPARTMENT OF FAMILY AND CHILDREN'S SERVICES OR TO THE LOCAL POLICE.

I ALSO UNDERSTAND THAT I MAY CANCEL THIS CONSENT TO TREAT AT ANYTIME BY SENDING WRITTEN NOTICE TO MY THERAPIST AT 299 COOPER ROAD, SUITE A, LOGANVILLE, GA 30052.

I UNDERSTAND THAT MY MENTAL HEALTH RECORDS WILL NOT BE RELEASED WITHOUT MY WRITTEN CONSENT AND THE CONSENT OF THE OTHER PARTICIPATING MEMBERS IN THE FAMILY THERAPY.

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you and/or your child(ren) provide during sessions is considered privileged by O.C.G.A. §24-9-21(7) during the psychotherapeutic relationship.

If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs.

OTHER RIGHTS

If you have concerns about your therapy services, please feel free to speak with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

TREATMENT FOR MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

TREATMENT PLANS

A treatment plan will be developed for your child. Part of this plan usually involves parent skills workshops or individual sessions to assist you and your family. Co-parenting education may also be a required part of your child's treatment goals.

CONFIDENTIALITY FOR MINORS

The confidentiality description provided on page 2 applies to your child. Please note that you and/or your child's information will not be shared with anyone other than the insurance or Medicaid provider without your written permission. (See HIPPA notice) You will also be asked to sign a release of information in order for me to share information with a third party.

Confidentiality with regard to psychotherapy is a special topic when the client is a minor. Parents must understand that a child's therapy is a special time when a trusting relationship develops. In order to respect your child's privacy, I will not usually share specifics of the sessions. I will, however, share with you areas of strength, concern, and/or provide general feedback and recommendations which I feel are relevant and important for you to know. You do have my assurance that if there is anything that you need to know, I will tell you immediately.

Please do not question your child with specifics or probe into what took place in their session. Likewise, what is discussed in family sessions should not be shared with others or discussed after the session.

LEGAL ISSUES:

Please be aware that I am not trained to perform custody evaluations. I will not use therapeutic sessions to evaluate custody disputes or visitation. I will work with families to help resolve conflict and minimize the effect of parental disputes on children.

I AGREE THAT I WILL NOT USE ANY INFORMATION GAINED THROUGH MY CHILDS THERAPY IN ANY WAY TO SEEK OR MODIFY CUSTODY. I AGREE THAT I WILL NOT USE CLINICAL DATA OR TREATMENT RECORDS FOR LEGAL PURPOSES. I WILL NOT GIVE MY CONSENT FOR ANY ATTORNEY TO SUBPOENA THERAPIST AND/OR CLINICAL RECORDS INVOLVING MY CHILD.

*I AM AWARE THAT THE LAW REQUIRES MY THERAPIST TO REPORT SUSPECTED CHILD ABUSE OR NEGLECT TO THE DEPARTMENT OF FAMILY AND CHILDREN'S SERVICES OR TO THE LOCAL POLICE.

I UNDERSTAND THAT THE MINOR CHILD MAINTAINS CERTAIN RIGHTS OF PRIVACY AND CONFIDENTIALITY IN HIS OR HER COMMUNICATIONS WITH THE PSYCHOTHERAPIST.

I ALSO UNDERSTAND THAT I MAY CANCEL THIS CONSENT TO TREAT AT ANYTIME BY SENDING WRITTEN NOTICE TO THERAPIST AT 299 COOPER ROAD, SUITE A, LOGANVILLE, GA 30052.

I UNDERSTAND THAT MY CHILD'S MENTAL HEALTH RECORDS WILL NOT BE RELEASED WITHOUT MY WRITTEN CONSENT AND THE CONSENT OF THE OTHER PARTICIPATING MEMBERS IN THE FAMILY THERAPY.

GEORGIA HIPAA NOTICE FORM

Notice of Clinician's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW CLINICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
- *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- *Health Oversight Activities* – If I am the subject of an inquiry by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, I may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are

being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. PATIENT'S RIGHTS AND THERAPIST'S DUTIES

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with a revised notice upon your next visit, or by mail at your request.

V. COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact your insurance provider.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. EFFECTIVE DATE, RESTRICTIONS, AND CHANGES TO PRIVACY POLICY

This notice will go into effect on June 1, 2007.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or at your next visit after any change is made.

(This page is for your records. Please sign on the next page.)

ACKNOWLEDGEMENT OF POLICIES

My signature below indicates that I have read the Informed Consent & Policies and Procedures and the Notice of Privacy Practices (HIPAA) and agree to their terms. I understand that copies of the HIPAA Notice Form and the current Policies and Procedures are available upon request and are posted at Mosaic Counseling Group.

_____

Signature of Client or Guardian

_____

Printed Name of Client or Guardian

_____

Date

CONSENT TO TREATMENT

I have read and understand the policies set forth by Mosaic Counseling Group, LLC. in the policy statement. My therapist has reviewed with me the nature and purpose of treatment. I have the right to refuse treatment at any point, and I understand the limitations of confidentiality and how my records will be handled. I hereby give my consent for treatment for _____.

_____ _____

Client or Guardian Signature Date

** If Mosaic Counseling Group will be billing your insurance company please sign below **

I hereby authorize Mosaic Counseling Group to furnish information to insurance carriers concerning the above named client concerning his/her condition and treatment and hereby assign to the therapist all payments for behavioral/mental health services rendered to the above named client. I understand that this authorization will remain in effect as long as the client remains in treatment**.** ***I accept full responsibility for all charges regardless of insurance coverage.***

_____ _____

Client or Guardian Signature Date

(Please return this page to Mosaic. You may keep the rest of this document for your records.)

ACKNOWLEDGEMENT OF POLICIES

My signature below indicates that I have read the Informed Consent & Policies and Procedures and the Notice of Privacy Practices (HIPAA) and agree to their terms. I understand that copies of the HIPAA Notice Form and the current Policies and Procedures are available upon request and are posted at Mosaic Counseling Group.

_____

Signature of Client or Guardian

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Printed Name of Client or Guardian

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Date

CONSENT TO TREATMENT

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I hereby authorize Mosaic Counseling Group to furnish information to insurance carriers concerning the above named client concerning his/her condition and treatment and hereby assign to the therapist all payments for behavioral/mental health services rendered to the above named client. I understand that this authorization will remain in effect as long as the client remains in treatment**.** ***I accept full responsibility for all charges regardless of insurance coverage.***

_____ _____

Client or Guardian Signature Date