Sophie Oswin, LPC

Journey to Equanimity Counseling and Consulting, LLC

1640 Powers Ferry Rd, Building #9, Suite #100

Marietta GA, 30067

#404-500-8045

Informed Consent for Psychotherapy

I am a licensed professional counselor and national certified counselor in the state of Georgia. I have a Master of Arts degree in Clinical Mental Health Counseling, and a PhD in Counselor Education and Supervision. I have extensive experience providing psychotherapy services for adults and adolescents. All billing and insurance inquiries are filed under my LLC: Journey to Equanimity Counseling and Consulting.

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. Benefits of counseling have been shown in many well-researched studies. However, change and the processes involved in creating positive change can at times be difficult and unsettling. In some cases, especially with children, symptoms worsen before improving. Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed.

After Hour Support and Emergencies:

Journey to Equanimity Counseling and Consulting, LLC is not an emergency services agency. I do not provide emergency services. If you have a life threatening or mental health emergency, please call 911. After you call 911 you may contact me during business hours at my business phone: 404-500-8045 and leave a confidential voicemail. I will call you back when I have finished all sessions or between sessions if possible.

Other after hour Mental Health Resources (not to be substituted for calling 911 with emergency):

1. **Ridgeview Institute at 770-434-4567**

2. **Peachford Hospital at 770-455-3200**

3. **Cobb Mental Health Crisis Line at 770-422-0202**

4. **National Suicide Prevention Hotline at 988.**

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If you should choose to communicate with me via email, phone, video, or text message, confidentiality cannot be guaranteed, and information may be accessible to others. Agreeing with this document indicates that you understand the risks of these methods of communication and that your therapist accepts no liability should your communication be compromised.

Telemental health sessions (video) may also be conducted through Simple Practice, which is a HIPAA compliant online platform for sessions. All video sessions will be billed at the regular session rate.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Social Media Policy

I do not connect with clients on social media sites. This is to protect your confidentiality and the integrity of the therapist/client relationship. Journey to Equanimity Counseling and Consulting may, however, have social media profiles for sharing general knowledge on mental health topics as well as for marketing purposes. Should you choose to interact (e.g., like, follow, comment) with these profiles you are doing so with the knowledge that all information can be seen by the public.

Property Damage

Any theft or damage to the property at 1640 Powers Ferry Rd, Building #9, Suite #100, Marietta, GA 30067 could be subject to criminal charges and the accused party will be fully responsible for the cost to repair or replace any damaged property. The value of damaged property will be assessed by the owners of building #9 and Journey to Equanimity Counseling and Consulting, LLC, who will do their best to estimate the fair market value of said property. The decision made by the aforementioned parties for the value of said property is final and by consenting to this document you acknowledge and agree that you will fully repay the aforementioned parties within 24 hours of receiving the price estimate. Should damage be caused by a minor or client(s) that are unable to be reached, their emergency contact or any immediate family member will take on this financial responsibility. In addition, any damage to property at 1640 Powers Ferry Rd, Building #9, Suite #100, will be financially liable to the owners for repair or replacement. In order to document potential theft or property damage, as well as maintain the safety of our clients, there are security cameras located on the premises. These security cameras are encrypted and are integrated into the security system, which will alert police/fire in case of emergencies. Surveillance footage is only taken on the outside stairwell as well as the common area inside of Building #9. All data is permanently deleted at regular intervals and is only accessible through two-step authentication by the owner of building #9. This is routine safety procedure for any privately owned company. Your privacy is our utmost concern, and we ensure that all possible steps have been taken to ensure your safety and confidentiality.

Offsite Therapy Sessions

When clinically appropriate, therapy sessions may be conducted offsite, such as “walk and talks” conducted outside of our building or at a nearby agreed upon location such as a trail. Although I do everything possible to ensure your confidentiality, such as walk in safe areas away from other people, we are not able to guarantee your confidentiality due being in a public environment. By signing this document, you agree to hold harmless and indemnify Sophie Oswin and Journey to Equanimity Counseling and Consulting, LLC, from any injuries that may occur offsite as well as any information that was not able to remain confidential due to being in a public area.

Scheduling and Cancellations

A minimum of 24 hours is required to cancel an appointment. If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, the session will be billed at the usual rate. If there is a true, unavoidable emergency or serious or contagious illness, please call as soon as possible and I will work with you to reschedule, and you may request waiver of the 24-hour policy.

Session Parameters

Parenting sessions, individual counseling sessions, and family sessions are 50 minutes. Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance

We will be happy to provide paperwork for you to file with your insurance company for out of network reimbursement. We cannot guarantee your insurance company will reimburse for the services.

All fees are paid directly to Sophie Lake Oswin, LLC. I accept cash, check, Master Card, Visa, Discover, and Amex, as well as HSA and HRA insurance cards.

A limited number of reduced fee slots are available with application and are extended based on financial need. Please ask me about reduced fee options. I will be more than happy to discuss alternative payment agreements prior to our initial intake session.

There is a **$25 fee for any returned checks.** That $25 fee is due at the time of your next session, along with the payment for that session. If two (2) returned checks are received from you, we will require that you pay using cash or credit card only from that point on.

15-minute Initial Consultation: Free

Intake Session and Follow Up Sessions: $150.00

Preparation of Summaries of Treatment or Letter: Prorated at standard fee. Court related: $600/hr. for all time spent on the case.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law to do this and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP). Please refer to the NPP for more information. Since we cannot cover all possible situations, please talk with your therapist about any questions or problems. The information about your health that is received from you or from others, mainly to provide you or your child with treatment, to arrange payment for services, or for other business activities, which are called in the law “healthcare operations.” If you do not consent and sign this consent, we cannot treat you or your child. Of course, we will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

1) When there is a serious threat to you or your child’s health and/or safety, or the health and/or safety of another individual and/or the public. We will only share information with a person who or organization that is able to help prevent or reduce the threat.

2) Some lawsuits and legal or court proceedings.

3) If a law enforcement official legally requires me to do so.

4) For worker's compensation and similar benefit programs.

There are some other situations like these that do not happen very often. They are described in the long version of NPP.

Client Records

You should be aware that, pursuant to HIPAA, we keep information about all clients in a collection of professional records. This constitutes your Clinical Record. We keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing, which will consist of Progress Notes written by your clinician. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, we recommend that you initially review them with your clinician in a scheduled session or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of $35 charged for copying and mailing the record for release.

Client Rights

HIPAA provides you with several new or expanded rights regarding your Clinical Records and disclosures of protected health information. These rights include requesting to amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about the policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures.

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services provided, we invite you to first communicate your concerns to your clinician directly so that we will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about your clinician with the licensing board and may do so by contacting the board at the following address and phone number: Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, 237 Coliseum Drive Macon, GA 31217-3858; (478) 207-2440.

Agreement to Enter into Counseling Services and Fee for Services Agreement

I have read or had read to me and understand all the information in the above paperwork. I have had a chance to review and ask questions and have all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, or clicking below that you agree, I am consenting to treatment and understand all the benefits and risks of counseling. I also hereby acknowledge that I have received the Notice of Privacy Policies.

Every time I schedule an appointment with my therapist, I understand that I am entering into a contract with Sophie Lake Oswin, Journey to Equanimity Counseling and Consulting, LLC and for the professional time and services provided for that appointment time. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agreed to pay the agreed upon amount and I agree to pay this fee at the time of each session. I understand that Journey to Equanimity Counseling and Consulting, LLC does not reimburse for cancelled appointments that were paid for in advance but that any such fees will be credited to your account and applied to future services provided. Should I fail to pay for any session(s) at the time of service, Journey to Equanimity Counseling and Consulting, LLC reserves the right charge your credit card on file. Should you not have a credit card on file or if your card is declined, I will contact you to collect payment. We understand difficulties arise and would be happy to work with you to resolve the matter; however, if payment has still not been received your name and any other identifying information will be sent to a collections' agency.

I understand that the cancellation policy requires 24 hours advance notice to be released from the contract for my therapist's time and services of preparation for my session. **I agree that if I fail to cancel my appointment within the 24-hour minimum time period prior to my session, I will be charged the usual rate for the appointment.** I also understand if there is an emergency situation that prohibits me from canceling within 24 hours, I can discuss this with my therapist directly and request a waiver of this policy.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____