WALLIS AND ASSOCIATES PROFESSIONAL COUNSELING SERVICES, INC

671 Lumpkin Campground Rd., Dawsonville, GA 30534 Office: 706.490.0204
www.walliscounseling.org

Confidentiality and Informed Consent

First Name: _____Last Name: _____ DOB: _____

Today's Date: _____

CONFIDENTIALITY

_____ Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person treated or evaluated, or such person's parent/guardian, and with the agreement of the counselor. There are exceptions to the confidentiality of information in the following circumstances (as provided by law): (1) Where there is a clear and imminent danger to the client or others, the counselor may take reasonable personal action or inform the responsible authorities; such as in, suspect of child abuse or suicidal ideation or homicidal ideation will be reported; and (2) if the counselor is required by a court to give information. Except as required by law, you, the client/parent/guardian must sign an authorization to release clinical records to the counselor to talk to or share clinical records or information with anyone, including referred doctors, insurance companies, or family members. All people attending sessions would be required to sign a consent to authorize release of clinical records. Counselors will be discreet if it is necessary to contact you at home or work. In keeping with generally accepted standards of practice, counselor frequently consults with other mental health professionals regarding the management of cases. The purpose of this consultation is to insure quality care. Every effort is made to protect the identity of clients, including any financial records (including payment via credit/debit card information).

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ACKNOWLEDGMENT OF DISCLOSURE

_____ The client/parent/guardian has the responsibility and right to (1) choose their therapists and the treatment modality that best suits their needs; (2) discuss with the counselor any concerns about treatment; (3) request a change in approach; (4) request referral to another therapist; and/or (5) discontinue therapy. The therapist can make no guarantees of results. The therapist follows the ethical guidelines set forth by the Georgia Counselors Association and the Georgia Composite Board of Professional Counselors.

_____ You have the right to obtain a paper copy of this notice from us, upon your request, even if you have agreed to accept this notice electronically. You are also agreeing that you have read the Notice of Privacy and agree with it, and a copy of your signature will be on file in your records

INFORMED CONSENT

_____ Psychotherapy may illicit 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.

_____ Psychotherapy 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.

_____ Your therapist is not a physician and cannot prescribe or provide you with any drugs or medication or perform any medical procedures. If medical treatment is indicated, your therapist will provide a referral to a physician or psychiatrist for you.

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CANCELATION POLICY AND FEES

_____ If you must cancel your appointment, please phone at least 24 hours prior to your scheduled time. You will be charged a flat fee of $50.00 for any appointment that does not meet this specification. Part of effective therapy to meet your goals is to be accountable for keeping your appointments.

CREDIT CARD ON FILE FOR UNPAID SERVICES

Cardholder Name: _____

Credit Card Billing Address:_____

City, State & Zip _____

Credit Card Type: ☐Visa ☐Mastercard ☐Discover ☐AmEx

Credit Card Number: _____Expiration Date: _____

Card Identification Number (CVV): _____

I authorize Wallis and Associates Professional Counseling Services, Inc to charge to my credit card provided herein any amounts due on my account. I agree to have Wallis and Associates Professional Counseling Services, Inc maintain my credit card information on file and automatically charge my credit card when payments are due. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I agree to inform Wallis and Associates Professional Counseling Services, Inc. within 15 days of any changes in credit card information, and I agree to pay any fees in the event my credit card is declined.

Cardholder –Sign and Date Below:

Signature: _____

Date: _____

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RELEASE OF INFORMATION

_____ HIPAA law requires that we have your written consent to release any of your mental health records. Please list the names and a contact phone number for anyone that you would like to allow access to your mental health record. You may also indicate the limits of disclosure.

By signing this Authorization, I authorize the use or disclosure of my individually-identifiable health information maintained by Wallis and Associates Professional Counseling Services. My health information may be disclosed under this Authorization to the following recipient:

Print name (person and/or organization): _____

Address:_____

City:_____ State:_____ Zip Code: _____

Health information that may be used or disclosed through this Authorization includes but is not limited to:

• Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
• Privileged communications between me and a licensed clinical social worker, licensed marriage and family counselor, or licensed professional counselor, or between them concerning my communications with any of them.

_____All the above health Information about me, including my clinical records created/received by the person or organization above
_____ All health information about me as described in the preceding checkbox, excluding the following (specify below):
_____Specific health information including only (specify below):

_____
_____
_____
_____
_____
_____

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I have read and understood the prior statements including **the confidentiality form, the disclosure information, the informed consent information, the appointment cancellation policy, and the information regarding consent to release records**. My signature indicates that I hereby give my consent for counseling services. I authorize Wallis and Associates Professional Counseling Services, Inc to render counseling services to the following:

_____

Client's Name (Print)

_____

Client's Signature

_____

Parent/Guardian (if applicable)

_____

Date