Restoration23 Counseling
3950 Cobb Parkway, Suite 604
Acworth, GA 30101

Client Informed Consent

We are pleased that you have sought counseling, and are committed to helping you identify and reach your therapeutic goals. It is vital for you, as client, to be fully informed about the therapy process. Your signature below indicates that you have received, read, and understand your rights and responsibilities under this agreement and consent to enter a therapy relationship with your counselor, based upon the terms of this agreement.

The Process of Counseling: It is our desire to provide a warm and trusting therapeutic relationship, wherein you feel safe to examine patterns of behavior, thoughts, or emotions that are causing concern. Treatment goals will be established via ongoing collaboration between you and your therapist. Your counselor may help you explore possibilities and consequences of decisions, but his/her role is not to make decisions for you as a client. The purpose of counseling is to support, facilitate and empower your growth toward greater psychological health and satisfaction. While the process is effective for many people, there are no guarantees of success.

Please free to ask your therapist any questions you may have. The nature of your concerns will be discussed and recommendations made concerning treatment. If your counselor is not a good fit for your needs, as the counselor determines, appropriate referrals will be made and a second session will not be scheduled.

As Christian counselors, we believe that God loves us and is eager and available to help in our quest for personal growth. Only upon your request, and to your comfort level, will we integrate Scripture and prayer in session. It is not necessary for therapeutic growth that you believe, express, or integrate spiritual views into therapy sessions or treatment goals. Each of our practitioners will operate from the highest level of respect and will regard your comfort level, personal and spiritual beliefs, and cultural diversity.

Services Offered and Clients Served: We offer a wide array of psychotherapeutic modalities in order to comprehensively treat individuals, couples, families, and groups. We provide services to adults, adolescents, and children.

Potential Counseling Risk: Participation in outpatient psychotherapy is strictly voluntary and may pose some risk. Therapy often involves experiencing a wide range of emotions, which may span a continuum of both positive and negative extremes. Due to the personal, pruning nature of the growth process, experiencing changes in your relationship with others may become a source of strain or difficulty for you during your therapy journey. Likewise, during the course of treatment, additional problems may surface which may shape or lengthen your treatment plan. Rest assured that our practitioners will continuously assess, relay, and collaborate with you on concerns and therapeutic goals. Therapy has also been shown to have many benefits...often leading to better relationships, increased self-esteem, solutions to specific problems, and significant reduction of emotionally distressing feelings.

Licensure: Our counselors are licensed by the State of Georgia, and are governed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. If your counselor is currently undergoing the process of licensure, she/he will be under the supervision of a Licensed Professional Counselor, as per the Composite Board requirements. Several Restoration 23 counselors engage in supervision and consultation as part of a commitment to best practice. If your care is discussed with a supervisor, your identity and privacy are protected.

Judy Holley, MA, LPC	License # LPC006519
Joseph Trey Mickler, MA, LPC	License # LPC003204
Libby Watson, MA, LPC	License # LPC006514
Sarah Zipfel, MA, LPC	License # LPC011377
Jennifer Wallace, MA, LAPC	License # APC006577
Tess Watson, MEd, LAPC	License # APC006617

Code of conduct: You can rest assured that as Licensed Professional Counselors and Licensed Associate Professional Counselors, we are required by state law to adhere to codes of conduct for practice that have been adopted by our licensing boards. We ask that a client contact his/her counselor if an ethical concern arises.

Confidentiality: Information shared by you in the counseling relationship is kept strictly confidential. We do not disclose client confidences and information to any third party, except under the following circumstances, and in accordance with state law: 1) The client signs a written release of information, indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, 3) There exists reasonable suspicion of abuse/neglect against a minor child, elderly person (60 years or older), or a dependent adult, or 4) A court order is received directing the disclosure of information. It is our policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. We will endeavor to apprise clients of all mandated disclosures as conceivable.

Minors and Parents/Guardians: Clients under 18 years of age who are not emancipated (and their parents) should be aware that the law allows parents to examine their child's treatment records, unless the provider believes that doing so would endanger the child, or we agree otherwise. However, because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is our general approach that during treatment the therapist will provide parents only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions...unless the therapist feels that the child is in danger and/or is a danger to someone else, in which case, we will notify authorities and/or parents or guardian of the concern. Before providing parents with sensitive information, the therapist will discuss the matter with the child, if possible, and do his/her best to therapeutically handle any objections he/she may
have.

Fees: Our professional therapy fee of $100.00 is based on a 50-minute clinical hour. Most of our counselors do not accept insurance as payment, although your individual counselor may be able to accept certain insurance plans. If necessary, your counselor may offer a sliding-fee scale based upon financial hardship. Please discuss any financial hardship you may have with your counselor upon intake.
If additional time is needed/utilized beyond the clinical hour, additional fees will be applied. Full payment (or insurance co-payment) is expected at the time of the service. You may pay with cash, check or credit card. A $30.00 charge will be assessed for returned checks. Clients whose account is in arrear may be unable to schedule a session until account is paid in full. You are responsible for any balance not paid by your insurance. Additionally, we require all clients

maintain a credit card on file, in the event of a missed session or an unforeseen balance developing.

Legal Proceedings:

If your therapist is subpoenaed to testify or submit records to the court, a fee will be assessed. For a written report, a fee of $150.00 will be charged. Because appearing in court requires canceling a full day of clients, you will be billed per day, for each day the counselor is required to report. The fee for the full day is $1000.00. You will be billed $50.00/per hour for preparation time. If the court appearance is more than 20 minutes away from the office at which you typically attend sessions, mileage will also be assessed.

Communication fee:

If your therapist spends in excess of 10 minutes communicating via phone/email with you, a prorated (quarter hour) fee for the time spent may be applied to your account. The client will be responsible for these charges, which are not billable to insurance.

Late-cancelation/No-show fee:

We value our time with you and craft our schedule accordingly. If a client does not show up for an appointment, or provide at least 24-hours notice of canceling the appointment, your provider's out of pocket rate will be assessed for each occurrence. Upon the third occurrence, payment will be expected in advance of session, along with an allowance of consideration of termination of ongoing services by your therapist. Exceptions may be warranted in the event of an emergency, or at the discretion of your therapist.

Client Responsibility: In order to receive the full benefit from the counseling relationship, it is essential that you contribute honest effort into the counseling process. If you are currently receiving services from another mental health professional, please inform us of this.

Physical Health: Findings show a strong connection between physical and psychological/emotional health. As a part of the initial evaluation, you will be asked to give the name of your primary care physician, describe your medical history, and list all medications you are currently taking. It is recommended that you have a physical examination if you have not had one within the last year.

Record Keeping: Clients will have a file created in his, her, or their name(s). The purpose of that file is to help the therapist remember relevant information and to carry out his/her

responsibilities effectively and efficiently. Files will be maintained for 7 years after termination of the counseling relationship, at which time the file will be destroyed.

Contact with your Counselor: Due to the nature of our profession, your counselor may not be available immediately via telephone. Clients are kindly asked to contact their counselor by email whenever possible. We strive to return all messages/emails by the end of the next business day.

Clients who need to cancel appointments are requested to do so at least 24 hours in advance. This can be done by logging into your client account at: https://app.acuityscheduling.com/schedule.php?owner=13723806, or by phone/email,

On the rare occasion your therapist needs to cancel your appointment, he or she will contact you. Every attempt will be made to provide at least 24 hours' notice of the cancellation. If you do not wish for us to contact you via phone or email, please notify us so that we can discuss an alternative arrangement.

Social Media Policy: Due to the confidential nature of the therapeutic relationship, our practitioners do not accept friend, follower, or message requests from clients on any social networking sites (Facebook, Instagram, Twitter, LinkedIn, Snapchat, etc). Connecting on social media can compromise your confidentiality, and our respective privacy.

Emergency Situations: Restoration23 Counseling is is not a crisis-based counseling practice. In case of a severe mental health or life-threatening emergency, please call 911 or proceed to the nearest hospital emergency department before contacting your therapist. If you are under the care of a psychiatrist, and your emergency is not life-threatening, please also contact his/her office.

Please save the following emergency phone numbers to your cell phone:

Local 24-Hour Crisis Line: (770) 422-0202

National Suicide Hotline: (800) 784-2433, or (800) 273-TALK

I have read the information above and choose to enter into a therapy relationship under the circumstances described.

_____	_____	_____
Client or Authorized Representative	Date	Relationship to the Client

_____	_____
Therapist	Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a patient, you have following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, please let your counselor know.

Effective Date of this Notice	1/1/2018
Contact Person	Sarah Zipfel
Phone Number	(770) 515-9023

Acknowledgment of Notice of Privacy Practice

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

_____

Patient or if minor Representative Name (please print)

_____ _____

Patient or Representative Signature Date

Credit/Debit/HSA Card On File Agreement

We require clients to maintain a payment method securely on file with Restoration 23 Counseling. You may still choose to make your payment by check, cash, or a card different from the card on file.

In providing us with your card information, you are giving your therapist permission to charge your credit card on file for your (or any other client(s) you have listed on this form) services, or counseling fees, outstanding balance, and co-pays/co-insurance. Please note, by choosing to pay with card versus cash/check, your therapist may apply a nominal service fee. Please discuss your preferred payment method with your practitioner.

Co-pays and co-insurances are due at the time of the office visit. Missed appointment and other non-insurance-billable fees will be charged at the time of the missed appointment or fee assessment. A receipt will be emailed to you by your therapist to your email address provided on this form.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. This agreement will expire upon termination of services and settlement of final balance.

All Information Must Be Completely Filled In Below:

Card Holder's Signature: _____
Date: _____

Visa ___ MasterCard ___Discover ___ American Express ___
Card Holder's Name (Please print): _____
Card # _____
Expiration Date: _____
CVV#: _____
Billing Zip Code: _____
Please fill out the information below for any other person(s) you authorize this credit card for:
If NO OTHERS ALLOWED, strike through and initial.
Client Full Name: _____DOB: __/__/____
Client Full Name: _____DOB: __/__/____

Restoration 23

CLIENT INFORMATION FORM

Today's date: _____

Your Name: _____
Last First Middle Initial

Date of Birth: _____ **Social Security #:** _____

Home Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email**: _____

Best phone for reaching you or leaving discreet messages. Please indicate any restrictions.

_____

Education: _____ **Highest Degree Obtained:** _____

Occupation: _____

Name of Employer: _____ **Phone:** _____

Spiritual Resources: _____ **Religious Affiliation:** _____

Referred by: _____
- May I have your permission to thank this person for the referral?

Yes No
- If referred by another clinician, would you like for us to communicate with one another?

Yes No

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Briefly describe your concern(s)which prompted you to seek counseling at this time:

_____

_____

_____

What are your goals for therapy? _____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _____

_____

Previous Hospitalizations: (Approximate dates and reasons): _____

_____

_____

Previous treatment with a psychiatrist, psychologist, or other mental health professional? YES NO

Name: _____ Dates: _____ Reasons: _____

RELATIONSHIP STATUS:

Poor Excellent

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships_____

FAMILY MEMBERS:

Relationship:	**Name:**	**Age:**	**Describe Relationship:**
Spouse/Partner	_____	_____	_____
Mother	_____	_____	_____
Father	_____	_____	_____
Other Primary Caregivers	_____	_____	_____
	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Describe any relationship problems you are experiencing at this time: _____

_____

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety				People in General				Nausea		
Depression				Parents				Abdominal Disease		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/ Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Problems				Heart Palpatations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in Joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

Please CHECK all that apply and CIRCLE the main problem(s):

Family History of (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression	
Legal Trouble			Sexual Abuse			Anxiety	
Domestic Violence			Hyperactivity			Psychiatric Hospitalization	
Suicide			Learning Disabilities			"Nervous Breakdown"	

Any additional information you would like to include: _____

_____

THERAPIST COPY

RESTORATION 23
3950 Cobb Pkwy. Suite 604
Acworth, GA 30101

COMMUNICATION CONSENT FORM

I, _____, grant consent for my mental health care provider, _____, to correspond with me via e-mail, text, home phone, cellphone voicemail and video call. This consent is for the purpose of scheduling appointments, or conveying general information about my treatment or the treatment of my child. This is NOT a consent to release information to any specific person other than the client (or the client's parent/guardian when the client is under age 18).

I understand that these communication modalities are not a secure form of communication and that confidentiality of any information cannot be ensured. I understand that these types of communication modalities are not to be used to communicate urgent matters or emergencies to my mental health provider. If one of those situations arise or we disconnect in the middle of a crisis, I am to contact 911, go to the nearest emergency room or call the crisis lines provided by this form and follow their direction. By initialing each modality, I am granting consent for my mental healthcare provider to communicate with me.

Home Phone: _____ Initial: _____

Cell Phone: _____ Initial: _____

E-Mail: _____ Initial: _____

_____ _____
Client Signature/Date WitnessSignature/Date

Crisis Lines:
Local 24-Hour Crisis Line: (770) 422-0202
National Suicide Hotline: (800) 784-2433, or (800) 273-TALK

Georgia Crisis and Access Hotline: 1-800-715-4225

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CLIENT COPY

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