Client Informed Consent

Center for Authentic Life & Relationship, LLC
1301 Shiloh Road NW, Suite 840
Kennesaw, GA 30144

Section I: About Me - Your Counselor / Therapist

Credentials

I am a Certified Advanced Alcohol and Drug Counselor (CAADC) through:

The Alcohol & Drug Abuse Certification Board of Georgia (ADACBGA)
6755 Peachtree Industrial Boulevard #110
Atlanta, GA 30360

http://www.adacbga.org/ADACBGA-contact

I am a Certified Sex Addiction Specialist (CSAT) and a Certified Sex Addiction Therapist Supervisor (CSAT-S) through:

The International Institute of Trauma and Addiction Professionals (IITAP)
P. O. Box 2112
Carefree, AZ 85377

http://www.iitap.com/

I am certified in EMDR Therapy & Treatment through:

EMDR International Association
5806 Mesa Drive, Suite 360
Austin, TX 78731

My Trainer: Dr. Laurel Parnell, Ph. D.

http://www.emdria.org/

I hold a license to practice *Professional Counseling* from the State of Georgia:

License No: LPC007769

I hold a license to practice *Marriage and Family Therapy* from the State of Georgia:

License No: MFT001409

I hold a certification as a Certified Professional Counselor Supervisor (CPCS) in the State of Georgia.

I have completed core skills training for Emotion Focused Couples Therapy and am currently working on obtaining a professional certification in an effort to continue the advancement of my knowledge and skill in couple and marriage work. (For more information, see: https://iceeft.com/what-is-eft/).

Education

I earned a Bachelor of Science Degree in Business Administration with a Major in Finance from the University of Alabama in Birmingham in 1980.

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I earned a Master of Arts Degree in Marriage and Family Therapy from Liberty University in 2010.

I completed three years of Addiction Psychology studies, with a 4.0 GPA, at the Ph.D. level at Capella University. I decided to stop pursuing this when my wife of 35 years died in early 2017.

Each year, I pursue a significant amount of training related to maintaining and renewing State of Georgia licenses and also professional certifications. Occasionally, I pursue trainings related to obtaining new professional certifications.

Initialing this section is your acknowledgement that I have provided you with information about my education, certification, and licensing credentials related to the professional practice as a provider of mental health services, addiction, and sexuality specialties in the State of Georgia.

Section I – Initials: _____

Section III: My Theoretical Orientation in Counseling

My overriding theoretical perspective would best be described as Systemic (Family Systems) Theory with a Psychodynamic and Attachment Theory focus. In this context, I use the following therapy protocols:

Eye Movement Desensitization and Reprocessing (EMDR) Therapy;
Ego State Therapy;
Internal Family Systems Therapy;
Psychotherapy with a Psychodynamic theoretical focus;
Cognitive Behavioral Therapies; and
Emotion Focused Therapy.

I also believe that the family is formed when two people marry. Families expand and evolve when the married couple either have their own children or adopt children. It is the family context that babies develop into individuals while at the same time, learning inter-relational interaction in intimate family relationships. Dr. David Olsen has contributed much to our understanding in this matter through his development of the *Circumplex Model*.

If one considers that babies must grow and develop, then psychodynamic theoretical foundations quickly become at least one set of frameworks by which this developmental process can be understood and discussed. In particular, there are times when the concepts of self-psychology and ego psychology inform my perspectives. At other times, object relations and attachment theory are applicable. In addition, there are times when concepts developed in interpersonal theory are helpful. In the domain of psychodynamic psychology and therapy, I am particularly influenced by the writings of Donald Winnicott, John Bowlby, Karen Horney, Melanie Klein, Heinz Kohut, Harry Stack Sullivan, and others.

My therapeutic methods involve assessment and evaluation processes along with individual work, marriage work, family work, and group work.

It is my opinion that clients must work to establish new mental structures which later become the foundation for new ways of living, including new relational patterns. Therefore, my counseling and therapeutic processes involve independent study, homework (including reading), and at times, involvement in self-help support groups.

Assessment and evaluation processes include the utilization of professional instruments for the purpose of providing quantifying and descriptive measurements to otherwise subjective information used in the

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formulation, development, confirmation, and refinement of any conceptualization(s) of your presenting problem(s) and the related techniques and interventions chosen as part of your treatment plan.

Section III – Initials: _____

Section IV: Your Rights as A Patient/Client

1. You have the right to ask questions about any procedures used during coaching, counseling, or therapy. If you wish, I will explain my approach and methods to you. If I see a person under the age of consent (which varies for different states/jurisdictions), all custodial parents with legal guardianship have a right to information shared in the session. Parents should be aware that exercising this right may be detrimental to the coaching, counseling, or therapeutic process, and so may wish to allow confidentiality between the minor aged child and therapist.

2. You have the right to decide not to receive coaching, counseling, or therapeutic assistance from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer. It is important for you to understand that it is very unusual to find someone who is able to provide you with professional services without cost. Unless a professional has some source of subsidizing the cost of your treatment services, charging a fee for services is their only source of personal income.

3. You have the right to end your participation in the coaching, counseling, or therapy process at any time without any moral or legal repercussions or concerns.

4. You have the right to end your participation in the coaching, counseling, or therapy process without any financial obligations other than those already accrued at the time you decide to stop participation.

   Should you decide to end your participation in the coaching, counseling, or therapy process with me, I ask that you contact me and let me know of your decision. I would also appreciate, although it is not required, a short explanation concerning your reason for making this decision. If there is something that I have done to offend you, talking with me about it – even if you do not change your decision – could be an important personal growth step for you.

5. You have a right to review your records. This can be done only in my office and only with a scheduled appointment for this purpose. This is necessary in order for me to have the opportunity to interpret the cryptic nature of some session notes that may be in your file. Under normal circumstances, I do not allow copies of your file to leave my office. Instead, I will make appropriate and necessary reports concerning the content of your file. Requests for such reports can be made by contacting my office. However, I will forward a copy of your file to other medical or mental health professionals who are trained to read and interpret the files contents.

6. One of your most important rights involves **confidentiality**. Within limits of the law, information revealed by you during coaching, counseling, or therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in coaching, counseling, or therapy, I view the family (all members present in the counseling and therapeutic process) as the client. Therefore, releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during any of the coaching, counseling, or therapeutic sessions.

   Limits of confidentiality are described below in Section VI.

7. If you disclose your HIV Antibody/AIDS status, your confidentiality will be maintained. ONLY WITH YOUR EXPLICIT WRITTEN PERMISSION will the information you have entrusted to us be shared with another organization. Under no circumstances will our organization, or any of its personnel, accept a verbal permission for disclosure of any of your medical/mental health information, including your HIV/Antibody/AIDS status.

8. If you request it, summary information concerning your file can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you. Such release will require your written request and authorization.

9. You have the right to know about the possible harmful results of coaching, counseling, or therapy when you are expecting to apply for insurance reimbursement. You should consider that harmful results might include:

    a. Denial of insurability when applying for medical and disability insurance due to DSM-5 or ICD11 diagnosis (mental illness diagnosis, which is required for reimbursements under medical insurance plans);

    b. Insurance company lack of control regarding your information when claims are processed;

    c. Loss of confidentiality due to the large number of persons handling claims;

    d. Loss of employment, and repercussions of diagnosis in situations which require truthfulness about ''mental illness'', including driver's licenses applications, concealed weapon permits, job applications, and possibly other situations not listed.

Section IV - Initials: _____

Section V: Ethical Codes

I ascribe to the following ethical codes:

The American Association of Marriage and Family Therapists (AAMFT)

The American Counseling Association (ACA)

The International Association for Trauma and Addiction Professionals (IITAP)

The National Association for Addiction Professionals (NAADAC)

The Alcohol & Drug Abuse Certification Board of Georgia (ADACBGA)

Section V – Initials: _____

Section VI: Limits of Confidentiality

You should also know that there are certain situations in which I am required by law to reveal information obtained during coaching, counseling, or therapy processes to other persons or agencies without your permission. Also, I am not required by law to inform you of my actions in this regard.

These situations are as follows:

1. If you threaten grave or bodily harm or death to another person, I am required by law to contact the appropriate authorities and/or warn the person you threaten of their potential danger;

2. If a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order;

3. If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authorities;

4. If you are in coaching, counseling, or therapy by order of a court of law, the results of the treatment ordered must be revealed to the court;

5. If you are using a third party payer such as an insurance company, I may be required to reveal confidential information to them in the process of obtaining their approval for services rendered.

6. If you are involved in an emergency situation, and you are not able to give or refuse specific permissions, I may, using my professional judgment, share limited information that I deem directly necessary for obtaining emergency care for you;

7. Information about you may be disclosed to a public health authority that is authorized by law to collect or receive certain information related to protecting the public regarding certain health concerns;

8. Information about you and your case may be disclosed to a professional supervisor in the context of my counseling case supervision. In addition, information about you and your case may be disclosed to appropriate members of my staff in discussing the best way to address your coaching, counseling or therapeutic needs;

9. Information about you or your case may be viewed by administrative or clerical staff in the normal course of operations concerning the administrative processes of my office; and

10. Your name, address, phone number, dates of service, and type of service may be provided to your credit card company should you dispute a credit card charge and your credit card company requests information about the credit card transaction.

Section VI - Initials: _____

Section VII: The Coaching, Counseling and Therapeutic Process

Coaching, counseling, and therapy will seek to meet goals established by the persons involved, usually related to a specific presenting problem. A major benefit that may be gained from participating in this process includes improving interpersonal relationships such as those in intimate relationships in the marriage and family context.

Another possible benefit may be a greater understanding of family and personal goals and values leading to a greater individual maturity and increased relational harmony. Other benefits relate to the probable

outcomes resulting from resolving specific concerns presented in the coaching, counseling, and therapeutic process. In working to achieve these potential benefits, the coaching, counseling and therapy process will require that you make firm efforts toward personal change. It is likely that this will involve experiencing significant personal discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended. The benefits of experiencing this discomfort may not be apparent to you until much later in the coaching, counseling, and therapeutic process.

It is also important to note that it is possible for your coaching, counseling, and therapy process to have an unexpected outcome. For example, it is possible for attempts to improve your marriage relationship to result in separation and/or divorce.

Section VII – Initials: _____

Section VIII: Marriage and Family Coaching, Counseling, and Therapy

In the context of marriage (or other relationship) coaching, counseling, and therapy and/or family coaching, counseling, and therapy, you acknowledge that consent to begin coaching, counseling and therapeutic treatment which will involve your spouse (or partner or some significant other person(s), or family member(s). You understand that this type of coaching, counseling, and therapy requires that you share your thoughts, feelings, issues, and experiences with me and potentially, with relational partners and/or family members.

You agree that if there are things that you explicitly do not want shared with your spouse, relational partner, or family member, it is your responsibility to explicitly request that this information not be shared.

There are times when I may determine that certain information needs to be shared in order to continue with the coaching, counseling or therapeutic process. If you disagree with the recommended coaching, counseling or therapeutic strategies and directives, or do not follow these directives, I may decide to terminate the coaching, counseling, and therapeutic relationship with you.

You understand and agree that participating in marital, relationship, and/or family coaching, counseling and therapy involves potentially experiencing increased emotional distress. You also understand that at times, information may be shared that is not only difficult for you to share, but is also difficult for others to receive and cope with. You understand that I may ask that you participate in individual coaching, counseling, and therapy prior to or during the course of marital, relational, or family coaching, counseling, and therapy. At any time during the course of your coaching, counseling or therapy process, I may meet individually with those involved in the coaching, counseling, and therapeutic process. I ask that you respect this decision and trust my professional judgment in these situations. Of course you are free to ask questions or share concerns about any such situation.

You also understand that marital, relationship, and/or family coaching, counseling, and therapy processes may not be successful and such processes may have an unexpected negative, distressful, and consequential outcome.

Section VIII - Initials: _____

Section IX: Concerning Minor Aged Persons

As the parent or legal guardian of a minor age person, you are consenting to assessment and treatment regarding the problems you are experiencing and for which you are seeking help concerning the minor

aged person. You understand that it may be necessary to participate in marital, relational, and/or family coaching, counseling, and therapy in order for the problem situation with the minor aged person to be resolved. In addition, it may be required that other professional providers be consulted in regards to treatment for the difficulty being experienced concerning the minor aged person.

It is my philosophy that parents have specific parental authority and rights concerning their minor aged children. However, in order to provide the most effective treatment regarding problems being experienced by a minor aged child, it may be necessary for me to withhold information from the parent or legal guardian regarding information shared by the minor aged child in the coaching, counseling, or therapy session. You are agreeing to trust my professional judgment as to when this relationship of confidentiality with your minor aged child should be violated. In other words, you are agreeing to allow me to withhold information from you concerning your child should I decide, in my professional judgment, that doing so is in the best interest of your child in achieving the desired therapeutic outcome.

Should it become necessary for your family to participate in family coaching, counseling, or therapy, you understand that your right to confidentiality may be limited – within the family setting – in order for the coaching, counseling and therapeutic work to be effective. You are welcome to schedule an individual session with me to discuss this if you develop concerns about this policy.

You understand that if your minor aged child is less than 12 years old, once he or she has been assessed, a treatment plan will be developed and you will be informed of and asked to agree with and participate in this treatment plan before any coaching, counseling or therapeutic process is initiated. If your child is 12 years of age or older, I will desire for your minor aged child to agree to the sharing of this information prior to you being informed.

Again, if at any time through the process, in my professional judgment I deem it necessary to violate this relationship of confidentiality with your minor aged child, I will contact you and ask for an appointment that will allow for the appropriate sharing of the necessary information including my concern(s).

It is important to note that if the minor age child's parents are divorced or separated, it will be required that the parent with custodial and guardianship responsibilities provide a copy of the court document demonstrating their legal right to make decisions on behalf of the minor aged child. In these cases, the other parent will be asked to validate that the presented document is the latest and therefore presiding (most current) document outlining parental, custodial, guardianship, and legal responsibility for the minor aged child. The other parent will be allowed to participate in the coaching, counseling, and therapy process to the degree that:

1. The official court document allows, and

2. The parent is cooperative and in my professional judgment is not being detrimental to the coaching, counseling, and therapy process concerning the minor aged child.

Information in ***Section VI: Limits of Confidentiality*** also applies concerning minor aged children.

Section IX - Initials: _____

Section X: Contacting Me

If you have a life threatening emergency, you should always contact emergency services personnel by immediately calling 911.

You also may contact me at (678) 516-6902. If I am serving another client at the time of your call, I will not be available to answer the phone. Please note that this is the ONLY number where you may leave a voice mail and get a timely response. Voice mail messages left at this number will be received during normal office hours during weekdays, except for holidays. You may expect a return call from me within a 48-hour period.

If you happen to leave a message on any other phone, you will not receive a response to your voice mail message. I realize that some may think this boundary is too strong. However, I pray that you will realize that it is simply impossible to work with people in coaching, counseling and therapy sessions all day, in addition to attending required meetings, and still have time to return messages from several different voice messaging systems in the evenings.

You should understand that any communication about your case that happens outside of your scheduled therapy session will incur a fee for service provided to you. **See Section XVII regarding fees**.

Finally, I reiterate that my preferred method of communicating with you is during a regularly scheduled phone or in-office counseling sessions.

Section X - Initials: _____

Section XI: Scheduled Appointment Times and Attendance

My normal office hours for meeting in person meetings with clients will be published and maintained on my website at http://www.royablankenship.com.

For session structure and fee information, see ***Section XVII: Fees and Length of Therapy***

As a courtesy to me and other clients, it is recommended that you be on time for your session appointment. Because of the number of people who seek and desire help with their problem situations, my schedule will often not accommodate same-day make-up time for late or missed appointments. In addition, you understand that your appointment will end exactly 60 minutes after it's scheduled start time, regardless of the time you arrive.

If you fail to attend your scheduled appointment without proper notification, refer to ***Section XII*** concerning ***Cancellations*** to review how I will handle this.

Section XI - Initials: _____

Section XII: Cancelations

If you cannot attend a scheduled coaching, counseling, or therapy session appointment, I require that you notify me at least twenty-four (24) hours prior to your scheduled appointment. If you fail to attend a scheduled session appointment without the expected notification, you will be required to pay my standard fee, or my contracted rate with your insurance carrier, for the missed session.

If you fail to attend more than 3 scheduled appointments, all future scheduled appointments will be canceled and I will terminate our therapist/client relationship.

Consideration will be made for poor weather conditions or personal circumstances such as the death of a family member or other emergency situations. Note that I will need to be in agreement with you that your situation is in fact an emergency.

Please note that if you are submitting claims to your insurance company for reimbursement, your insurance company will not reimburse you for charges related to missed sessions. In other words, you will be personally responsible for the cost of the missed session.

Your respecting of this policy is a courtesy to me that will allow me to utilize my available time effectively in attempting to help the largest number of people who are seeking assistance.

Section XII - Initials: _____

Section XIII: Concerning Tele-Mental Health

In the State of Georgia, Tele-Mental Health is defined as follows:

"Tele-Mental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. Tele-Mental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

Tele-Mental Health is a relatively new concept despite the fact that many therapists have been using technology assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Tele-Mental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in Tele-Mental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The different forms of technology-assisted media are explained as follows:

Telephone via Landline: It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Telephone via Mobile Phones: In addition to landlines, cell/mobile/smart phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging: Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication

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strictly for appointment confirmations. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email: Email is not always a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, & etc. It is my policy not to accept "friend" or "connection" requests from any current or former client on my personal social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship. However, I have a professional Facebook page and professional Twitter account. You are welcome to "follow" me on any of these professional pages where I post information related to my counseling & therapy work. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to mine on the social media platform. Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Blogs: I may post information related to my counseling and therapy work on my professional blog. If you have an interest in following my blog, please feel free to do so. However, please be mindful that the general public may see that you're following my blog. Once again, maintaining your confidentiality is a priority.

Video Conferencing (VC): Video Conferencing is an option for us to conduct remote sessions over the Internet where we not only can speak to one another, but we may also see each other on a screen. At the present time Skype is NOT willing to sign a BAA and is not recommended. Therefore, I utilize video conferencing (VC) tools that are encrypted to the federal standard, are HIPAA compliant, and have signed a HIPAA Business Associate Agreement (BAA). The BAA means that the VC is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment. I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the Internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps): During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

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Electronic Transfer of PHI for Billing Purposes: If I am credentialed with and a provider for your insurance, please know that I utilize a billing service who has access to your personal health information (PHI). Your PHI will be securely transferred electronically to Insert Billing Company Name Here. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions: I utilize SquareUp.com, Intuit Merchant Services, and SimplePractice.com as the companies that processes your credit card information. These companies may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Roy A. Blankenship and/or Center for Authentic Life & Relationship, LLC.

Your Responsibilities for Confidentiality & Tele-Mental Health: Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Tele-Mental Health sessions.

In Case of Technology Failure: During a Tele-Mental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me. If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to my phone service, and we are not able to reconnect, I will not charge you for that session.

Limitations of Tele-Mental Health Therapy Services: Tele-Mental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Face-to Face Requirement: If we agree that Tele-Mental Health services are the primary way we choose to conduct sessions, I may require one face-to-face meeting at the onset of treatment, if possible. I prefer for this initial meeting to take place in my therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

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Your Consent to Tele-Mental Health Services: Please check the Tele-Mental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

1. ___ Video Conferencing Tools
2. ___ Mobile/Cell Phone
3. ___ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Section XIII - Initials: _____

Section XIV: What to do in an Emergency

- If you are experiencing the threat of suicide regarding yourself or someone else, please ***immediately*** call 911. Also, call the suicide crisis hotline at: 1-800-SUICIDE.
- If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:
- If you have a life threatening emergency, please call 911 immediately, or go directly to the nearest hospital emergency room.
- If you are experiencing a situation which may result in harm to you or someone else, please call 911 ***immediately***.
- Call Behavioral Health Link/GCAL: 800-715-4225 or another 24-hour crisis hotline in your area
- Call Ridgeview Institute at 770.434.4567 or your local hospital
- Call Peachford Hospital at 770.454.5589 or your local hospital
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Go to the emergency room of your choice.

If we decide to include Tele-Mental Health as part of your treatment, there are additional procedures that we need to have in place specific to Tele-Mental health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and therefore, Tele-Mental Health services are not appropriate.

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- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above.

  Please list your ECP here:

  Name: _____Phone: _____

  Address: _____

  Relationship to You: _____

- You agree to inform me of the address where you are at the beginning of every Tele-Mental Health session.

- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Tele-Mental Health session). Please list this hospital and contact number here:

  Hospital: _____

  Address: _____

  Phone: _____

Section XIV Initials: _____

Section XV: Recording of Counseling Sessions

In some cases, I may desire to audio or video record your coaching, counseling, or therapy session for clinical training and supervision purposes. If I decide to record your session, you will be made aware of this before the session begins. You have the right to refuse to participate in a recorded session. However, in such cases, I may choose not to provide you with coaching, counseling, or therapeutic services.

Recorded sessions will never include any identifying information other than the exact information included on the recording media during the coaching, counseling, or therapy session.

Recorded materials will be maintained with confidentiality and in a secure location for the length of time I feel that is necessary regarding your case or the amount of time I determine to be useful for clinical training and supervision purposes. After that time, the recording will be destroyed.

Section XV - Initials: _____

Section XVI: Information Concerning Your Counseling Case

It is not uncommon for clinical practitioners to write professional articles or teach groups of students, interns, counselors, therapists, psychiatrists, and medical doctors (i.e., other clinical or professional

practitioners) on specific subjects regarding coaching, counseling, therapy, and mental health issues. It is possible that your case will be referred to in such a setting. In such cases, as is customary in the professional community of clinical practitioners, all identifying information will be removed and nothing will be written about or shared that would in any way identify the particular case as belonging to a particular person, married couple, or family. Of course, should you read the actual case history, it would feel very familiar to you and similar to your situation since in essence, it would be a recounting – without personal information disclosed – of your particular story.

Your agreement is your consent to help in teaching and training other professionals in the professional mental health community.

Section XVI - Initials: _____

Section XVII: Participation in Research

I may decide to incorporate data from your assessment instruments and selected data from your case history into a database of information for the purpose of discovering trends and patterns in mental health issues concerning alcohol use, substance use, and sexuality, marriage, and/or family concerns.

In all cases, your information will be kept confidential and no personal identifying data will be recorded in any research information database.

You are agreeing for your personal data to be utilized in an effort to help gain insights into how to help bring healing into the lives of people who are struggling with life issues.

Section XVII - Initials: _____

Section XVIII: Fees and Length of Therapy

I offer primarily face-to-face therapy sessions. However, based on your treatment needs, I may provide services via phone or video conferencing (Tele-Mental Health).

The structure and cost of in-person sessions, Tele-Mental Health sessions, and telephone/email correspondence (requiring more than 5 minutes outside of a scheduled session) is:

- $150 per 55-minute session;
- $225 per 80-minute session, and/or
- $85 per 90-minute group therapy session

unless otherwise negotiated with you or your third party payee, if applicable.

In some cases, I may reduce my fee for people in hardship cases.

I do not use a sliding scale regarding my fee structures.

For clinical supervision cases, I will negotiate the fee with you prior to the initiation of a professional supervision or a consultation relationship.

The fee for sessions will be due at the conclusion of each session.

PLEASE NOTE: My regular hourly fee for a face-to-face therapy session applies for responding to court subpoenas, or for appearing in court on your behalf and you will be charged for the amount of time spent

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either responding to your subpoena request and/or any court appearance related to you. Please be aware of this cost, and advise your attorney of these costs, before including me in any legal strategy regarding your current legal situation.

If I am working with you in a case management context, either singularly, or in conjunction with therapy, my above stated fees apply.

Should you require a written report, during your therapeutic engagement with me or sometime in the future, regarding any treatment, assessment, or evaluation that you engaged me to perform, my normal hourly fee (stated above) for a therapy session will apply and you will be charged this hourly fee for time spent on your behalf.

Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment.

I will provide you with a detailed receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you.

Please note that there is a $30 fee for any returned checks.

Phone calls, texting, and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding.

I require a credit card ahead of time for Tele-Mental Health therapy for ease of billing.

I require a credit card to be kept on file for payment of services rendered. This credit card will be used for insurance co-payments, insurance claims applied to your deductible, and services rendered that are not related to a third party payer such as an insurance company.

If I have provided it to you, please sign the Credit Card Payment Form authorizing me to charge your credit card without you being physically present. Your credit card will be charged at the conclusion of each in-office or Tele-Mental Health interaction. Or, I may provide you with a link where you may pay for services via the internet. **Again, this includes any therapeutic interaction other than setting up appointments.**

If I am a contracted provider for your insurance company, the following applies:

a) The Center for Authentic Life & Relationship, LLC will not verify your insurance benefits. This is your responsibility.

b) It is important for you to be aware that a quote of benefits, made by your insurance company, is not a guarantee of benefits or payment for the services you receive from the Center for Authentic Life & Relationship, LLC. At the time of claim submission, when the insurance company more closely compares the services provided to your insurance plan, and should a discrepancy arise between their processing of the claim and the quote of benefits they made earlier, the insurance company will make determinations about requests for payment based on your insurance plan, not the quote they originally provided. In other words, you will be held responsible for services provided that your insurance company decides not to cover.

c) As stated above, it is the policy of the Center for Authentic Life & Relationship, LLC that payment is due at the time of service unless other financial arrangements, in writing, are made in advance. You will be expected to pay any deductible, copay, and/or coinsurance payment at the

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conclusion of your session. You will also be expected to pay for services not covered by any third party payer.

d) If you are covered by an insurance provider for which the Center for Authentic Life & Relationship, LLC is contracted with, and if your insurance plan provides mental health and/or behavioral health benefits, the Center for Authentic Life & Relationship, LLC will bill your insurance company for services.

e) At the conclusion of your therapy engagement with the Center for Authentic Life & Relationship, LLC, you will be billed for any outstanding balances that remain after your insurance company has paid your claim to the Center for Authentic Life & Relationship, LLC.

f) Although the Center for Authentic Life & Relationship, LLC is contracted with certain insurance carriers/providers, our services may not be covered by your particular health insurance plan. Being referred to our center by another medical or mental health professional does not necessarily imply or guarantee that your health insurance carrier/provider will cover our services.

g) Some insurance carriers provide plan management services for other insurance plan providers. In such cases, both insurance company names may be listed in your insurance card. It could be that I am contracted with the insurance company managing your plan and not contracted with the insurance company providing your insurance plan. It is important for you to realize that in the end, you are responsible for verifying your insurance covers my services and obtaining any preauthorization required, if any.

h) It is important for you to be aware and understand that the acceptance of your insurance by the Center for Authentic Life & Relationship, LLC, does not place financial responsibilities for payment of services onto the Center for Authentic Life & relationship, LLC and you will be held accountable for any unpaid balances on your account with the Center for Authentic Life & Relationship, LLC.

i) Please remember that you are 100% responsible for all charges incurred by you or on your behalf.

j) Once again, please remember that your insurance company's referral and our verification of your insurance benefits are not a guarantee of payment. It is highly recommended that you also contact your insurance provider and check into your health insurance plans coverage for mental health and/or behavioral health services.

k) And, please do not assume that you will not owe anything because you have more than one health insurance policy.

Concerning out-of-network benefits:

- Should you use an out-of-network benefit option available under your insurance plan, it is your responsibility to contact your insurance carrier and make sure you understand what benefits your insurance plan provides when you use the Center for Authentic Life & Relationship, LLC as an out-of-network provider.

- The Center for Authentic Life & Relationship, LLC will not process or submit these claims on your behalf. You will be responsible for submitting claims for services I provide as an out-of-network provider.

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- You will be responsible for the full cost of services provided.

- In many cases, your insurance will reimburse you some percentage of the cost of my services, that they cover under your plan, but only after you have met your deductible. In other words, claims you submit will be applied to your deductible until the amount of all submitted claims accumulates to the amount of your insurance plans deductible amount. Until this deductible amount is reached, you will be responsible for the entire cost of services provided. After this deductible amount is reached, your insurance plan may cover some percentage of the cost of services covered under your plan. Again, please remember that it is your responsibility to contact your insurance carrier and make sure you understand this process.

- Finally, you understand that I have the right to recoup any unpaid balance on your account through legal means. In any attempt to collect on your account, my office will disclose your name, address, phone number, the fact that you are responsible for coaching, counseling, or therapy services, the amount you owe, and any other demographic information necessary regarding efforts to obtain payment on your account.

Section XVIII - Initials: _____

Section XIX: Other Considerations – Alcohol and Substances

You will not be allowed to attend any individual, marriage, family, or group coaching, counseling, or therapy session, or participate in any other counseling related program offerings, while under the influence of alcohol or any illegal substance or any mind-altering prescription drug, regardless of your perceived ability to function and cope.

If you drive a motor vehicle to your appointment while under the influence of alcohol or drug(s), for your safety, and the safety of others, I may choose to notify the police prior to you leaving my office in order to ensure that you are not operating a motor vehicle while impaired. Please note that in such instance, your rights regarding confidentiality will be waived to the extent necessary to ensure your safety and the safety of others you may encounter while driving under the influence of alcohol or drug(s).

Section XIX – Initials: _____

Section XX: Other Considerations

I. Violence

Anger is a natural emotion that you may experience during your coaching, counseling, or therapeutic experience. It is important that you take time to process through your anger either with me or with some other professional you trust and with which you feel comfortable.

It is important also for you to understand that verbal or physical threats of violence toward others involved in your coaching, counseling, or therapeutic experience (in a group context, in the family context, in the marriage context, with my staff, etc.), including me, will result in the immediate termination of my coaching, counseling, or therapeutic relationship with you. In such cases, the appropriate Sheriff's Office or the appropriate Police Department will be notified (via 911) and a report of the incident will be made with the appropriate law enforcement agency.

Section XX – Initials: _____

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Section XXI: Other Considerations – Referrals

If at any time during the course of your coaching, counseling or therapeutic process I decide that for some professional reason your presenting problem would be better addressed by a different professional service provider, I will talk with you about seeing a different life coach, counselor, therapist, mental health professional, or medical doctor. At that time, I will discuss with you my reasoning and offer you suggestions concerning who I think you should choose to help you in continuing your coaching, counseling, or therapy, or medical needs. In such a situation, it will be your responsibility to make contact with that professional and schedule an appointment.

I will make a summary report to that professional outlining my work with you in the coaching, counseling, or therapy process including my thoughts concerning why I determined that a referral was necessary or in your best interest.

Section XXI- Initials: _____

Section XXII: Organizational Affiliation

You agree that it has been explained to you that Roy A. Blankenship and/or the Center for Authentic Life & Relationship, LLC neither have any affiliation with either the First Baptist Church of Woodstock, Georgia or The HopeQuest Ministry Group, Inc.

Section XXII – Initials: _____

Section XXIII: Should You Be Offended or Find Yourself in a Disagreement with Me or Someone to Whom You Were Referred

It is not uncommon for someone to experience discomfort in the counseling and therapeutic process. It is also not uncommon for people to share their discomfort with their pastor, Sunday school teacher, spouse, friends, and family members in the format of objections, disagreements, concerns, and/or debate concerning what was experienced in the coaching, counseling, or therapeutic context. As a courtesy, if you experience something in your interaction with me that you disagree with, please tell me first. Give me the opportunity to make things right with you. Often, therapeutic change occurs in the context of this discomfort. By including others before you allow me the opportunity to dialogue with you about the issue, you may be denying yourself the opportunity to achieve the very transformation and change goals that you hoped to achieve in the coaching, counseling, or therapeutic process.

Section XXIII – Initials: _____

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XXIV: Give Your Consent

By signing this document, you are indicating that you have read the above information regarding informed consent, that any questions you may have concerning this informed consent have been addressed, and that you are in agreement with the terms and conditions set forth herein regarding any coaching, counseling, or therapeutic practice and processes. In addition, your initials at the end of each Section indicate that you have read and understood the information presented in each section.

Your signature indicates that you have been provided answers to any questions you may have about this document and the informed consent process.

Your signature also indicates that you agree to the policies, defined herein, of your relationship with me and that you are authorizing me to begin treatment with you.

Your signature also indicates that you agree that this document replaces any previously signed informed consent documents with the Center for Authentic Life & Relationship, LLC.

Client Printed Name: _____

Home Address: _____

City, State, Zip: _____

Phone: _____ (Indicate Home/Work/Cell)

Phone: _____ (Indicate Home/Work/Cell)

Email: _____ (Indicate personal/work)

__ Yes __ No: Permission to send appointment reminders via text

__ Yes __ No: Permission to send appointment reminders via email

Birth Date: _____/_____/_____

Client Signature: _____

Date: _____

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Below is for Parent / Legal Guardian (If client is a minor aged person) – if more than one, please provide information below on each parent. Each parent will need to also, along with the client, initial each section of this document.

By signing this document, you are indicating that you have read the above information regarding informed consent, that any questions you may have concerning this informed consent have been addressed, and that you are in agreement with the terms and conditions set forth herein regarding any coaching, counseling, or therapeutic practice and processes. In addition, your initials at the end of each Section indicate that you have read and understood the information presented in each section.

Your signature indicates that you have been provided answers to any questions you may have about this document and the informed consent process.

Your signature also indicates that you agree to the policies, defined herein, of your relationship with me and that you are authorizing me to begin treatment with you.

Your signature also indicates that you agree that this document replaces any previously signed informed consent documents with the Center for Authentic Life & Relationship, LLC.

Printed Name: _____

Relationship to Client: _____

Home Address: _____

City, State, Zip: _____

Phone: _____ (Indicate Home/Work/Cell)

Phone: _____ (Indicate Home/Work/Cell)

Email: _____ (Indicate personal/work)

__ Yes __ No: Permission to send appointment reminders via text

__ Yes __ No: Permission to send appointment reminders via email

Birth Date: _____/_____/_____

NOTE: If you are divorced, it is required that you attach a copy of the divorce decree indicating your custodial rights regarding the minor aged person. If you have shared custodial/guardianship rights, then the minor aged persons other parent must also be a signatory on this document.

Client Signature: _____

Date: _____

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By signing this document, you are indicating that you have read the above information regarding informed consent, that any questions you may have concerning this informed consent have been addressed, and that you are in agreement with the terms and conditions set forth herein regarding any coaching, counseling, or therapeutic practice and processes. In addition, your initials at the end of each Section indicate that you have read and understood the information presented in each section.

Your signature indicates that you have been provided answers to any questions you may have about this document and the informed consent process.

Your signature also indicates that you agree to the policies, defined herein, of your relationship with me and that you are authorizing me to begin treatment with you.

Your signature also indicates that you agree that this document replaces any previously signed informed consent documents with the Center for Authentic Life & Relationship, LLC.

Printed Name: _____

Relationship to Client: _____

Home Address: _____

City, State, Zip: _____

Phone: _____ (Indicate Home/Work/Cell)

Phone: _____ (Indicate Home/Work/Cell)

Email: _____ (Indicate personal/work)

__ Yes __ No: Permission to send appointment reminders via text

__ Yes __ No: Permission to send appointment reminders via email

Birth Date: _____/_____/_____

NOTE: If you are divorced, it is required that you attach a copy of the divorce decree indicating your custodial rights regarding the minor aged person. If you have shared custodial/guardianship rights, then the minor aged persons other parent must also be a signatory on this document.

Client Signature: _____

Date: _____

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