Restoration23 Counseling
3950 Cobb Parkway NW, Suite 604 - 606
Acworth, GA 30101

Client Informed Consent

Welcome to counseling. We are committed to helping you identify and reach your therapeutic goals. It is vital for you, as a 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 provider, based upon the terms of this agreement.

The Process of Counseling: We aim to provide a warm and trusting therapeutic relationship in which clients feel safe to examine patterns of behavior, thoughts, or emotions that are causing concern. Treatment goals will be established through ongoing collaboration between the client and the therapist. Your provider 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 feel free to ask your practitioner 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. 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 to comprehensively treat individuals, couples, families, and groups. We provide services to adults, adolescents, and children. Additionally, several of our clinicians offer coaching services.

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 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 a significant reduction of emotionally distressing feelings.

Licensure: Our practitioners 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 inform you and will be under the supervision of an LPC, LMSW, or CPCS as per the Composite Board requirements. Several Restoration 23 associates 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.

Joseph Trey Mickler LPC- LPC003204
Sarah Zipfel LPC- LPC011377
Leslie Cobb CLC
Christy Morrow LPC LPC015510
Sarah Brainard LCSW- CSW009404
Marie Stone LCSW- CSW002728
Tara Jiminez LPC CPCS (2029)- LPC008472
Brandon Wilson LAPC - under the supervision of Victoria Griffin LPC, CCTP, CPCS

Code of conduct: As licensed practitioners, we are required by state law to adhere to codes of conduct of ethical practice that have been adopted by our licensing boards. We ask that a client contact Sarah Zipfel (sarah@restoration23.com) or Trey Mickler (mickler@restoration23.com) 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 reasonably possible.

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. Please keep in mind, however, that privacy in therapy is often crucial to successful progress, particularly with teenagers. With adolescents, it is our general approach that the therapist provides parents with only essential details of treatment on a need-to-know basis, unless the therapist feels that the child is a danger to self or others. In these rare cases, the therapist will notify emergency authorities and/or parents or guardians of the concern. In cases where a court order is in place regarding custody and/or medical/mental health decision-making of a minor, the client will be asked to provide said documentation to the practitioner.

Fees: Our rates vary between practitioners and services. Your practitioner may be able to accept certain insurance plans. In cases of financial hardship, your provider may offer a sliding-fee scale based upon financial hardship. If additional time is needed/utilized beyond the clinical hour, additional fees may be applied. Full payment (or insurance co-payment) is generally expected at the time of the service via a prearranged payment platform. A $30.00 charge will be assessed for returned checks. Clients whose accounts are in arrears may be unable to schedule a session until the account is paid in full. You are responsible for any balance not paid by your insurance. Additionally, we require all clients to maintain a credit card on file, in the event of a missed session or an unforeseen balance due to a missed session or associated fee.

Legal Proceedings: If your practitioner is subpoenaed to testify or submit a letter or records to the court, a fee will be assessed to your payment method on file. For a written report, a fee of $150.00/preparation hour will be charged. Because appearing in court often requires canceling a full day of clients, you will be billed per day for each day the counselor is under subpoena or agrees to testify. This fee is $1000 per day and $150/hour for preparation time. If a court appearance is more than 20 minutes away from Restoration 23's office, mileage will also be assessed.

Communication fee: If your therapist spends in excess of 10 minutes communicating via phone/email with you between sessions, 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: We value our time with you and reserve our time with you accordingly. 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 our website or directly contacting your provider 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.

If a client does not show up for an appointment or does not provide at least 24 hours' notice of cancellation, your provider's hourly rate will be assessed for each occurrence. Upon the third occurrence, payment may be expected in advance of the 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: To receive full benefit from the therapeutic relationship, you must be dedicated to the process. Your provider may recommend a particular frequency of attendance or outside-of-session homework or support groups. 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 provide 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 within 24 hours.

Social media: Due to the confidential nature of the therapeutic relationship, our practitioners likely will not accept friend/follower requests or direct message requests from clients on their personal social networking sites (Facebook, Instagram, X, LinkedIn, Snapchat, etc). Connecting on social media can compromise your confidentiality and our respective privacy. If your practitioner has a professional social media page, you are most likely welcome to connect or follow them there.

Emergency Situations: Restoration23 is not a crisis-based practice. In case of 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 numbers to your cell phone:

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

I have read the information above and agree.

___________________________ (Print Client Name)

____________________________ (Signature of Client/Authorized Representative)

____________________________ (Relationship to Client)

_______________(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 the 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 ensure 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	Trey Mickler
Email	mickler@restoration23.com

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, 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 their individual practitioner. You may still choose to make your payment by check, cash, or a method different from the card on file.

In providing us with your card information, you are permitting us to charge your card on file for your (or any other client(s) you have listed on this form) services, or counseling fees, legal prep fees, outstanding balance, and co-pay/co-insurance. Please note that 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 upon intake.

Co-pays and co-insurance are due at the time of the office visit. Missed appointments 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 the 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 the final balance.

_____Please initial here that you understand and agree to Restoration 23's Card on File policy.

CLIENT INFORMATION FORM

Today's date: _______________

Your Name: ____(Last, First, Middle Initial)

Date of Birth: ____________________

Home Street Address: ____ **City:** ____ **State:** _______ **Zip Code:** __________________ **Home Phone:** _________________________ **Work Phone:** ___________________________ Cell **Phone**: _____________________ **Email**: _______________________________________

Best circle phone for reaching you or leaving discreet messages (work/ cell). Please indicate any restrictions below.

____

Education: ______________________________ **Highest Degree Obtained:** _____________________________

Occupation: ____

Name of Employer: ____ **Phone:** ______________________________

Spiritual Resources: ________________________ **Religious Affiliation, if any:** ___________________________

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. **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? ___

Do you use any non-prescription drugs? (Please remember that this form is completely confidential). YES/ NO

If YES, what kind 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:

Currently in a relationship? ____ How Long? ___

Relationship Satisfaction: 1 2 3 4 5 6 7 (Poor to Excellent)

Married/Life Partnered? _____ How Long? _____

Previously Married/Life Partnered? YES / NO

If so, length of previous marriages/committed partnerships___

FAMILY MEMBERS:

RELATIONSHIP	NAME	AGE	BRIEF DESCRIPTION OF RELATIONSHIP
SPOUSE/PARTNER			
MOTHER			
FATHER			
OTHER PRIMARY CAREGIVER(S)			
BROTHER(S)			
SISTER(S)			
CHILDREN			

Describe any relationship problems you are experiencing currently:

____

DIFFICULTIES CHECKLIST:

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: ____

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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 (CIRCLE ALL THAT APPLY). 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 arises 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, then contact my provider.

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

Crisis Lines:
Local 24-Hour Crisis Line, Highland Rivers Behavioral Health: (770) 422-0202
National Suicide Hotline: 988 [call or text]
Georgia Crisis and Access Line (GCAL): 1-800-715-4225