Informed Consent Psychotherapy or Consultation

Felicia Berry-Mitchell, Ph.D. Clinical Psychologist
Providence Residential & Outpatient PTSD Services, LLC dba PROPS

Please complete this consent form as it will allow me to begin to understand your specific personal needs; therefore honesty is important. This and other information you disclose to me, is private and confidential with a few exceptions, which will be detailed below. Please ensure you have read, understood, and discussed any and all questions with me. This informed consent is an essential part of our therapy contract. The fee for an initial evaluation session without insurance or direct pay is $250 for individuals (per 83 minute session) and $300 for couples (per 1 hour 50 minute session). Ongoing therapy appointments are $175 (per 53 minute session) for individuals and $225 (per 70 minute session; additional $50 for each 15 minutes thereafter) for couples. Payment is due at the time of service. If you have insurance, your rates are based on our contract with your insurance company and you are responsible for any copay or deductible due.

Confidential Data Form

____________________ ____________________ ____________________
First Name Middle Name Last Name

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Address

__________________________ __________________________
Home Phone # Work Phone #

May messages be left at these numbers? Home Yes____ No_____ Work Yes____ No____

______________________________ ____________________
Email Address Cell Phone

_____/______/_______ _____ __________________________
Birth date Age Social Security #

__________________ __________________ __________________
Marital Status Employer Referral Source

Do I have your permission to contact the person who referred you? ________

How do you prefer to be contacted for appointment reminders? ___________

Please describe any previous involvement in Counseling or Psychotherapy you have had:

Please tell me how you heard about my services:

I generally conduct an interview in the first session. Are there particular concerns that you would like to discuss then, as the interview and any needed assessment are the focus of this session?

No show/Cancellation policy: You are responsible for all regularly scheduled sessions. **I must have 24 hours notice to waive the fee otherwise you will be billed a $100 service charge for appointments M-F 9 a.m.- 5 p.m. and $150 for appointments scheduled after 5 p.m. M-F and on weekends**. Your insurance company cannot be billed for missed sessions; you are solely responsible for this fee. Additional appointments will not be scheduled or held until the fee is paid. ***Initial here***__________

No show/Cancellation policy Medicaid Patients: If you do not show or do not cancel 24 hours in advance of your appointment twice, you may not be seen and your treatment terminated.
Initial here__________

Late arrivals: If you are more than 15 minutes late to your appointment, your appointment may be rescheduled, and you are subject to the No Show/Cancellation fee. **Initial here**__________

Insurance Reimbursement: Reimbursement requests sent to your insurance company include a diagnosis, which is required for insurance reimbursement.

Confidentiality and HIPAA Privacy Rules: I am mandated by the ethical and legal standards of Psychology and the State of Georgia to act to keep you and others safe; State law and professional ethics require Psychologists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. In cases in which serious threat to a well-identified victim is communicated to me (threat to others).
3. When threat to injure or kill oneself is communicated to me (threat to self).
4. If you are required to sign a release of confidential information by your medical insurance carrier or for psychotherapy records if you are involved in litigation or other matters with private or public agencies.
6. Clients being seen in couple, family, and group work are obligated to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality from others) when disclosing private information to other participants in your treatment process
7. I may speak with colleagues about our work without asking permission: your identity will be protected.
8. Clients under 18 do not have full confidentiality from their parents.
9. It is also important to be aware of other potential limits to confidentiality that include the following:

a) All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in secure and encrypted digital and electronic format but some are in locked files. Files are cross-shredded for further privacy.
b) Cell phones, portable phones, faxes, and e-mails are used on some occasions.
c) All electronic communication compromises your confidentiality.
10. If your account is sent to a collections agency for non-payment
Please initial here that you have read the limits to confidentiality agreement _____________.

Fees: The client will pay any fees and copays due at the beginning of each session. Cost of living increases may occur on an annual basis for direct pay clients. Telephone calls may be charged if over 5 minutes in length; you may request a rate list. Interest at 12% per annum will be charged on all accounts over 30 days due. No further treatment will be provided until the account is brought forward. You are encouraged to discuss the possibility of a sliding scale fee or other arrangements, to maintain the continuation of your treatment. If your account is not paid after 30 days, a collection agency may be asked to collect the debt on behalf of Dr. Berry-Mitchell and Providence Residential & Outpatient PTSD Services, LLC.
Initial here____________________

Availability: The therapist is available for regularly scheduled appointment times; walk-ins are not allowed. Dates of vacations and other exceptions will be given out in advance if possible. You can schedule an appointment by calling the office number during regular office hours at 770-577-PTSD (7873).

Contacting Dr. Berry-Mitchell:
You can reach Dr. Berry-Mitchell or her staff who may be able to assist you at 770-577-7873 (office) and 678-882-5371 (cell) via text or calls until 6 p.m. M-F. Life-threatening messages should NOT be left as these calls will be followed up by the authorities for a welfare check to ensure timely attention to your safety and/or that of others. Most calls are followed up within 24-48 hours M-F. *Use discretion when leaving messages as the message may be received by another staff member other than your assigned therapist.*

Emergency service can be obtained by calling:
National Crisis Line at 1-800-273-TALK (8255) 24/7, calling 911, or presenting to the nearest emergency room. You should also present to or call one of the facilities below based on proximity to you:
a) Willowbrooke at Tanner at 770-836-9551 on their 24-hour help line (W. GA area)
b) Cobb Wellstar at 470-732-4000 (Austell & Lithia Springs area)
c) Wellstar Paulding at 470-732-3789 (Paulding Co & surrounding areas)
d) Ridgeview Institute at 770-434-4567 (S. Cobb Co. area)
e) Peachford Hospital at 770-454-2302 (Atlanta, Chamblee, Dunwoody, area)
f) Grady Hospital at 404-616-6200 (downtown & metro Atlanta)
g) Riverwoods 877-394-5271 (South Atlanta region)

Termination of Treatment: The Client may terminate treatment at any time. The therapist may terminate treatment if payment is not timely, if interventions are not consistently adhered to, if you do not pursue recommended consultation, if you do not refrain from dangerous practices, for

coming to sessions under the influence of illicit or known addictive substances, including prescription or OTC medications, for abusive or disrespectful language and/or behavior, or if some problem emerges that is outside my scope of competence. Please discuss any issues you have interpersonally with your therapist or other staff member so that we have an opportunity to resolve the matter and provide a corrective experience for you. If you drop out of active therapy and do not follow up with your therapist in 60 days, unless otherwise indicated and agreed upon by you and the therapist, your record will be closed to limit liability and discontinue your therapist's assignment as your mental health provider. The usual termination for ongoing treatment is a minimum of four sessions but an appropriate termination to long-term work may be longer.

Potential Side Effects of Therapy:

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Therapy may be emotionally painful at times but you and the outcome affects to your life deserve the healing and transformative benefits that therapy can bring. Having outside support during therapy is important.

Psychotherapy

Psychotherapy usually begins with an assessment of symptoms and behaviors that often interrupt your social life, personal relationships, school or work activities, and physical health. Self-knowledge is instrumental in changing attitudes and behaviors. Therapy is designed to help you understand how your feelings and thoughts affect the ways you behave, perceive yourself, and others.

Therapy outcomes are dependent upon your willingness and ability to engage, and commit to, the therapeutic process and complete assigned interventions. Change takes work and if you wish to change your life you must be willing to work daily at improving your current condition. You are worth the effort.

Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings toward the therapist. The therapeutic relationship is a model for all others and being able to discuss differing viewpoints and express emotions and thoughts in a safe place can be a transformational experience.

Psychotherapy can be relatively short-term (4-16 weeks) when the focus is limited to specific symptoms or problem areas and longer if the treatment targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date is set.

Theoretical Orientation:

Dr. Berry-Mitchell has primarily been trained in, and uses Cognitive Behavior Therapy (CBT) and other treatments that have CBT as their foundation such as Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Dialectical Behavior Therapy (DBT). Cognitive Behavior Therapy is the "Gold Standard" in mental health care and has extensive research to reflect its

effectiveness with a wide-range of mental and behavioral health problems, as well as substance abuse issues. Cognitive refers to our thoughts and beliefs. CBT is a teachable skill-based treatment that allows the Client to learn how to challenge and correct unhealthy thoughts and beliefs that cause him/her to feel "stuck", experience mood and behavior problems, interpersonal difficulties, problems at work, school, play, etc., and in various roles in their lives.

Briefly Identify Your Goals For Therapy:

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Dr. Berry-Mitchell's Goals & Holistic Approach: The goal of therapy as your psychologist is to help you achieve your treatment goals and to help you reclaim your life and recognize the strengths you possess to confront any future challenges. It is my goal to equip you to meet current and future challenges by teaching you skills you can apply that will increase your sense of efficacy and competence. This process includes incorporating your mind, body, and spirit to achieve these goals. It is not my place to impose my beliefs on you. Spirituality can refer to organized religious beliefs and practices, interacting with animals, being out in nature, or listening to music; whatever makes you feel alive and connected to something outside of yourself is what we want to incorporate into our work together, barring it is NOT an illegal or unethical practice. Please acknowledge here that you understand the goals, in part, and holistic approach, of Dr. Berry-Mitchell regarding your treatment. _____________ ***Initial here***

Agreement for Psychotherapy and Consultation

I have read this informed consent completely and have raised any questions I might have about it with Dr. Berry-Mitchell. I have received a satisfactory response to any questions I may have asked and agree to the provisions freely and without reservations. I understand that I will be fully responsible for all legal and/or collection costs arising due to my contact with Dr. Berry-Mitchell, including appropriate compensation for her time involved in preparing for and completing paperwork and forms for disability, benefits, employment, time away from work or school, reasonable accommodations, statements regarding mental status, etc., preparing for and presenting for court, or any other activity where her signature is provided identifying her credentials. The time to prepare for, and present this information is NOT covered by your insurance company as it is not provision of psychotherapy, psychological evaluation, or any billable covered mental health service. I understand that Dr. Berry-Mitchell will not complete such paperwork/forms unless I am an established patient of hers, having seen her for a minimum of eight sessions. I understand that Dr. Berry-Mitchell, from time to time makes teaching, marketing, professional, and research contributions using disguised client material. By consenting to treatment, I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration. _______________ ***Initial here***

Arbitration Agreement

I agree to address any grievances I may have directly with Dr. Felicia Berry-Mitchell immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be

considered as a complete resolution and legally binding decision under state law. In agreeing to treatment, you are consenting to the aforementioned grievance procedures. *Signing below does not waive any of your legal rights.* This agreement constitutes the entirety of our professional contract; any changes must be signed by both parties. I have a right to keep a copy of this contract.

Client 1 Signature_____________________________ Date ___________

Client 2 Signature_____________________________ Date ___________

Therapist Signature ___________________________ Date___________

Legal Parent or Guardian Signature ____________________Date ________

Person(s) you give permission to Dr. Felicia Berry-Mitchell to communicate with in the event of an emergency (medical emergency, danger to self, danger to others or psychological distress):

Contact Name: _________________________ Relationship: _________________
Phone: ____________________ Address: __________________________

Contact Name: _________________________ Relationship: ________________
Phone: ____________________ Address: ____________________________

*To be completed by Dr. Berry-Mitchell:

SI____ HI____
AH____ VH____
OH_____ TH_____
GH_____ Oth Psych____________________________________
Delusions_____ Thoughts/Paranoia______________________________

Statement of Felicia Berry-Mitchell, PhD

This document was discussed with _________________________ and questions regarding fees, diagnosis, and treatment plan were discussed. I have evaluated _________________________'s mental capacity and found the client capable of giving an informed consent on this date.

Date_______________ and Initial of Therapist ________.