Shelley Watson, LPC
Informed Consent

This document is intended to provide you with all the details you need to make an informed decision about your care. Please print and read this document thoroughly. Initial the bottom of each page where indicated, sign pages 4 and 5, keep pages 6-7 for your records, and bring the pages 1-5 with you to your first appointment.

At the beginning of your first session, we will spend a few minutes reviewing this document so that I can answer your questions and make sure that you are comfortable before we begin.

QUALIFICATIONS: I earned a Master of Arts degree in Professional Counseling from Richmont Graduate University and a Bachelor of Arts degree from The Pennsylvania State University. I am currently a Licensed Professional Counselor (#LPC009166) by the state of Georgia.

AFFILIATIONS: I am a member of the American Counseling Association (ACA), the American Association of Christian Counselors (AACC), and the National Association of Alcohol and Drug Addiction Counselors (NAADAC).

NATURE OF COUNSELING: Counseling is a mutual and collaborative process. It is not something I do "to you", but something that we do together. As such, you have the right to participate in defining your treatment goals and your treatment plan. Many of my therapeutic techniques and methods designed to help you reach your counseling goals are based on psychodynamic theory. In general, this means that I will often be working to bring unconscious processes into your awareness and looking at how your past life experiences are impacting your experience of the world today. I also incorporate family systems theory with the belief that we are all part of a system of people in which we are influenced and are influencing others. I may suggest that we invite others from your "system" (spouse, parent, child, etc.) to counseling sessions occasionally to gain this perspective, but you have the final say in who participates in your therapy.

My services will be practiced in a professional manner that is consistent with the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage & Family Therapists and the American Counseling Association qualifications for ethical standards. You are entitled to an explanation of your condition and the treatment that will be provided, as well as the probable duration, benefits, and risk involved. Please know that it is impossible to guarantee any specific results regarding your counseling goals for the counseling process; however, together we can work to achieve the best possible results for you.

BENEFITS AND RISKS
Counseling has both benefits and risks. Counseling has been shown to have benefits for people who undertake it. It often leads to reduced feelings of distress, resolution of specific problems, and improvement in relationships with others. Potential risks and unpleasant aspects may include experiencing uncomfortable feelings like sadness, guilt, anxiety, anger, and frustration. You may also recall unpleasant memories, question relationships, make lifestyle adjustments, or reevaluate beliefs and values. It is important to consider that such experiences are a normal aspect of the counseling process, and I am available to talk with you about any of these issues as they arise.

TREATMENT ALTERNATIVES
There are alternatives to counseling that may also be beneficial for the symptoms you're experiencing. Alternative procedures may include marital counseling, family therapy, personal programs, medical interventions, prescription medication, 12-step groups, self-help books, and even no treatment at all. Each of these alternatives may also have potential benefits and risks. If during the course of our work together, we discover problems outside the scope of my practice, I will assist you in obtaining a referral to an appropriate specialist for the necessary services. I may also suggest one or more of these alternatives to you with my rationale for why I think it may be helpful to you. As in all cases, you are free to pursue or decline the recommendation.

CONFIDENTIALITY: The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA

provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to all heath care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is included in this document on pages 6-7.

Communications between client and counselor are confidential and will not be revealed unless required by law, or in the course of providing you with competent care. Such situations include:

1.) child abuse or elder abuse

2.) threats of physical harm to self or others,

3.) for clinical supervision or consultation purposes,

4.) if subpoenaed by a court of law,

5.) to provide a defense in situations in which such information is necessary for me to defend against a disciplinary board complaint or malpractice action brought by the client,

6.) if a guardian ad litem (GAL) is appointed in a custody case involving adolescent clients I have seen for counseling services and she/he is ordered by the court to have access to mental health practitioners and records,

7.) in the context of The Patriot Act of 2001, which requires me in certain circumstances to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

There are several other circumstances that impact confidentiality that you should be aware of:

1.) I am happy to provide paperwork for you to file with your insurance company; however, in doing so, there will be a diagnosis required with the paperwork and there may be a violation of your confidentiality, as insurance companies do not always observe the same strict confidentiality polices that I do.

2.) I am willing to share information about our counseling sessions with any other professional or agency that you wish, provided you sign a Release of Information form.

3.) In working with adolescents, though legally the parent(s) or legal guardian(s) of adolescent clients are the client and confidentiality lies with the client, I honor what the adolescent does or says in our sessions as confidential while providing parents and/or legal guardians with summaries of treatment goals, plan and progress as well as recommendations. This is essential for establishing and preserving my relationship with the adolescent.

4.) In working with couples and families, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family, although sessions with individuals in the couple/family may be a part of the couples/family therapy. I will not be a "secret keeper" nor will I facilitate secret keeping. If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it or I may have to terminate the therapeutic relationship and refer you to another therapist.

COUNSELING FEES: The standard fee for a 55-minute session is $130, which includes time for handling administrative details such as scheduling the next appointment, etc. I ask that you keep your account current and pay by credit, cash or

check at the end of the session (make checks out to Shelley Diefenbach, LLC). I do not accept insurance, but am happy to provide you with a receipt at the end of the session if you wish to file your own insurance claim. If you are experiencing financial hardship, please speak to me about this so I can work with you. In the event of lack of payments received for 2 sessions, no further sessions will be conducted until the balance is paid in full or other arrangements are made.

OTHER FEES:
Please be aware that I charge for and expect payment for phone time (after the first 10 minutes) and for non-session time related to you requested by you. Payment is due at your next session following the rendering of these services. I will provide a statement for you upon request.

Phone calls longer than 10 minutes	Prorated using the standard counseling fee
Requested non-session time*	$130 an hour (E.g. consultations with others at your request)
Requested paperwork time*	$130 an hour (E.g. writing reports related to you at your request)
Returned check	$20 for a check returned for "insufficient funds"

* These fees only apply to services requested by you, at which time I will remind you of the associated fees and ask you to confirm the request. These fees do not apply to time I spend in personal supervision, consultation, treatment planning, case review, session notes, or any other activities I do as part of providing you with competent and ethical care.

SCHEDULE: I offer appointment times on Mondays (10:00AM – 7:00PM), Wednesdays (10:00AM – 7:00PM), and Fridays (10:00AM – 5:00PM). My office is at 5755 North Point Parkway, Suite 249, Alpharetta, GA 30022.

You may schedule, change, or cancel appointments by calling or texting me at 404.919.4563.

CANCELLATION OF APPOINTMENTS: If you must cancel your appointment for any reason, please call or text me at 404.919.4563 the day before your scheduled appointment. If you miss your appointment, or do not notify me the day before your appointment, you will be billed at your full session rate.

LATE APPOINTMENTS: Each appointment begins at the scheduled time and lasts for 55 minutes. If you arrive late for an appointment, the appointment will begin shortly after your arrival and end at the normal time. If I am running late, I will either offer to extend the session over the expected ending time to make up the difference, or accept a prorated fee for the remainder of the session time. Prorating will be based on your full session fee.

CORRESPONDENCE: If you need to contact me, you can text or leave a message at 404.919.4563, or email me at shelley@shelleywatsonlpc.com. We can use email, text, or other electronic correspondence to discuss scheduling, appointment information, homework assignments, and information regarding payment status. Because there is no way to ensure that electronic communication channels are secure and confidential, I will not use them to discuss therapeutic information. While I will take reasonable, precautions to protect your confidential information, if you choose to send me therapeutic information over these channels, you do so at your own risk. I strive to respond to emails, texts, phone calls, and other correspondence received outside of our sessions times within one business day (Mon-Fri, 9:00AM-6:00PM).

EMERGENCY PROCEDURES: My counseling office is not staffed with a receptionist or paging system, therefore I am not equipped to handle emergency situations. In the case of an emergency, I recommend you contact either a hospital emergency room or the police depending on the situation. You can also call the Georgia Crisis Line at: (800) 715-4225. In the event that you are unable to care for yourself during the course of a session, or agree to go to the hospital to ensure your safety or the safety of others, I will call 911 to transport you to the nearest hospital and call your Emergency Contact provided on your Intake Information form. You will be responsible for costs incurred.

There may be other situations in which I may deem it necessary to contact your Emergency Contact. Some of those situations may include but are not limited to: concern that you are in danger or hurt, evidence that you are unable to keep yourself safe, or knowledge of suicidal intent/planning. In the event that I speak to your Emergency Contact, I will use my discretion to provide only information that is pertinent to the current situation.

LEGAL DOCUMENTATION: You may have a legal situation that requires documentation from your therapist. I am happy to provide this for you, but require a minimum of one week's notice to produce the documentation. It is best to provide me with a copy of your conditions of probation at the onset of therapy so that I can work with you to produce the needed documentation in a timely manner. Depending on the level of effort required to produce the documentation, additional fees may apply.

PUBLIC CONTACT: In the event that you see me outside of the counseling office, my policy is to not acknowledge you until or unless you acknowledge me first so that your confidentiality is protected. If you choose not to acknowledge me, I will not be offended as it is completely dependent upon your level of comfort and desire for discretion.

DIVORCE/CUSTODY DISPUTES: If you ever become involved in a divorce or custody dispute, I am not able to provide evaluations or expert testimony in court; you should hire a different mental health professional for evaluations or testimony that you may require. This is because: 1) my statements will be seen as biased in your favor because we have a therapeutic relationship and 2) the testimony might affect our therapeutic relationship and I must put this relationship first. By signing this Informed Consent document, you are acknowledging your full understanding of and agreement on my position concerning this matter.

DUAL RELATIONSHIPS: Counseling is a professional service I am providing to you. Because of the nature of counseling, our relationship has to be different from other relationships. Dual relationships create conflicts between therapeutic interests and your best interest. In order to offer my clients the best care, my judgment needs to be professional at all times, and therefore dual relationships avoided whenever possible. In the event that a dual relationship cannot be avoided, I will initiate an open discussion with you about the possible risks so that we can decide together how to proceed. Examples of dual relationships include:

- Becoming your supervisor, teacher or evaluator
- Developing a social relationship outside of counseling
- Providing counseling to my own relatives, friends or people I know socially
- Providing counseling to people I used to know socially
- Forging any other kind of business relationship besides counseling
- Providing legal, medical, financial or any other type of professional advice

I, _____, fully understand the information provided to me in this document and agree to these terms and conditions. I voluntarily request counseling services from Shelley Watson, LPC.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

Shelley Watson, LPC

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all heath care providers, including mental health care, and providers and health care agencies throughout the country are required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights on the following two pages is my attempt to inform you of your rights in a simple yet comprehensive way. Please read this document, as it is important that you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find that I make every effort to do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, I am required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

I have received a copy of Shelley Watson, LPC, Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and I may at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy of the Patient Notification of Privacy Rights document.

_____

Client Name (Printed)

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

Shelley Watson, LPC

Patient Notification of Privacy Rights

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION. (EFFECTIVE 4-14-03)

LEGAL DUTIES: State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. We are required to abide by these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to me in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide me and I abide by ethical and legal requirements of confidentiality and privacy of records.

USE OF INFORMATION: Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is my policy not to release any information about a client without a signed Authorization to Release Information form except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

DUTY TO WARN AND PROTECT: When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

PUBLIC SAFETY: Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

ABUSE: If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES: Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH: In the event of a client's death, the parents or spouse of a deceased client have a right to access their child's or spouse's records.

PROFESSIONAL MISCONDUCT: Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

JUDICIAL OR ADMINISTRATIVE PROCEEDINGS: Health care professionals are required to release records of clients when a court order has been placed.

MINORS/GUARDIANSHIP: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

OTHER PROVISIONS: When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the timeframe, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the nature of the call, but rather my first name only. If this information is not provided to me, I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying myself. If the person answering the phone asks for more identifying information, I will say that it is a personal call. I will not identify the nature of the call (to protect confidentiality). If I reach an answering machine or voice mail, I will follow the same guidelines.

YOUR RIGHTS: You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1 per page, plus postage. You have the right to cancel a release of information by providing me a written notice. If you desire to have your information sent to a location different than the address on file, you must provide this information in writing. You have the right to restrict the information that might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing. You have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. This request must be made to me in writing.

COMPLAINTS: If you have any questions regarding these procedures, please don't hesitate to ask. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Georgia Board of Counseling. If you file a complaint, I will not retaliate in any way.