building blocks
Family Counseling

Main Address:
205 S. Skinner Ave. Unit B
Pooler, GA 31322
912-349-8043
www.buildingblocks.solutions

Professional Disclosure Statement

Informed Consent

Welcome to Building Blocks Family Counseling where we provide solutions to build healthy families. We are very pleased that you selected our practice for your care, and we sincerely look forward to assisting you. This document is designed to inform you about what you can expect from therapy with your therapist, policies regarding confidentiality and emergencies, and several other details regarding your treatment here. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist is a collaborative one, and they welcome any questions, comments, or suggestions regarding your course of care at any time.

What is Therapy?

Our therapists are required to have graduate training (a Master's or Doctoral degree) in their professional field and at least two years of clinical experience post master's before they are eligible to obtain full independent licensure. Additionally, they are also required to pass the national board exam before obtaining their license. Therapists are mental health professionals trained in psychotherapy, as well as licensed to diagnose and treat mental and emotional disorders. We are required by law to uphold the rules and regulations put upon us by the State of Georgia. Your therapist's scope of practice and Georgia law does not allow your therapist to provide custody evaluations of any type. Your therapist also does not provide disability evaluations or recommendations as well as fit for duty or work recommendations. Your therapist does not provide medication or prescription recommendation nor legal advice, as these activities do not fall within their scope of practice. These will be left up to the appropriate provider and if need be; your therapist can provide recommendations to these professionals.

The Process of Therapy; Risks and Benefits

As with any treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in your community may mistakenly view anyone in therapy as weak, or perhaps as seriously disturbed. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should also know that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives. Your therapist does not take on clients they do not think they can help. Therefore, your therapist will enter your relationship with optimism about your progress.

What to Expect from Our Relationship

As a professional, your therapist use their knowledge and skills to help you. This includes following the standards of the Georgia Composite Board of Professional Counselors, Marriage and Family Therapists and Social Workers and the applicable code of ethics. In your best interests, these ethical codes put limits on the relationship between a therapist and a client, and your therapist will abide by these. Let me explain these limits, so you will not think they are personal responses to you. First, I am licensed and trained to practice psychotherapy—not law, medicine, finance, or any other profession. I am not able to give you good advice from these other professional viewpoints. Second, state laws and our code of ethics require me to keep what you tell me confidential (that is, private). You can trust me not to tell anyone else what you tell me, except in certain limited situations. (Explained in the HIPAA Notice Privacy Practices.) Here I want to explain that I try not to reveal who my clients are. This is part of my effort to maintain your privacy. If we meet on the street or socially, I may not say hello or talk to you very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship. Third, in your best interest, and following the code of ethics, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.

About Confidentiality

I will treat with great care all the information you share with me. It is your legal right that our sessions and my records about you be kept private. That is why I ask you to sign a "release-of-records" form before I can talk about you or send my records about you to anyone else. In general, I will tell no one what you tell me. I will not even reveal that you are receiving treatment from me. In all but a few rare situations, your confidentiality (that is, your privacy) is protected by state law and by the rules of my profession. The details are outlined on the HIPAA notice of Privacy Practices that you have received.

There are two situations in which I might talk about part of your case with another therapist. I ask now for your understanding and agreement to let me do so in these two situations. First, when I am away from the office for a few days, I have a trusted fellow therapist "cover" for me. This therapist will be available to you in emergencies. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality. Second, I sometimes consult other therapists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private.

Your name will never be given to them, and they will be told only as much as they need to know to understand your situation. If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access. There is an exception to confidentiality because of the family nature of the therapy I provide. I do not keep family secrets from family members as I think that secrets are often at the root of family problems. I also will not go behind your back. Instead, if you reveal something to me that I feel would be something important to share with your family members I will talk to you about it and encourage you to disclose that information yourself, or even help you in that disclosure.

Consultations

If you could benefit from a treatment I cannot provide, I will help you to get it. You have a right to ask me about such other treatments, their risks, and their benefits. Based on what I learn about your problems, I may recommend a medical exam or use of medication. If I do this, I will fully discuss my reasons with you, so that you can decide what is best. If you are treated by another professional, I will coordinate my services with them and with your own medical doctor.

If for some reason treatment is not going well, I might suggest you see another therapist or another professional in addition to me. As a responsible person and ethical therapist, I cannot continue to treat you if my treatment is not working for you. If you wish for another professional's opinion at any time, or wish to talk with another therapist, I will help you find a qualified person and will provide him or her with the information needed.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies

Video Monitoring and Recording: There may come a point in treatment when your therapist may request to video record/film sessions. Prior to filming, your therapist will discuss the terms and agreements as well as having a separate consent form signed. The client always has the option to not give consent.

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with her. Out of respect for yourself and the therapeutic process, your therapist does ask that all clients silence their phones and do their best not to respond to messages or take calls during therapy.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. Please note that your therapist does not accept or

send texts as a way of communication with the exception to remind of appointments. Appointment reminders via text and email are sent from an automated system that you will not be able to respond to. Email will not be used for crisis situations or as a substitute for therapy. We ask that email only be used for brief matters of communications that can allow for a 24-48 hour response time. You also need to know that we are required to keep a copy of all emails and other electronic communications as part of your clinical record. If you find the need to communicate frequently with your therapist between sessions, it may be that you need to schedule more frequent visits. You are encouraged to protect your own confidentiality by controlling access to your communications with your therapist such as by using passwords only known by you, controlling access to your computer, etc. Please discuss with your therapist the preferred way for communicating outside of session.

Facebook, LinkedIn, Instagram, Pinterest Etc: It is your therapist's policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. You may "like" the Building Blocks Family Counseling Facebook page as this is a community page where upcoming events and helpful information are shared. We also encourage all clients to sign up to receive the Building Blocks weekly newsletter which is filled with blog posts, helpful tips, and upcoming events.

In summary, technology is constantly changing, and there are implications to all of the above that your therapist may not realize at this time. Please feel free to ask questions, and know that she is open to any feelings or thoughts you have about these and other modalities of communication.

About Our Appointments

The very first time I meet with you, we will need to give each other much basic information. We will usually meet for a session once a week, then less often. We can schedule meetings for both your and my convenience. I will tell you at least a month in advance of my vacations or any other times we cannot meet.

I will reserve a regular appointment time for you into the foreseeable future. I also do this for my other patients. Therefore, I am rarely able to fill a cancelled session unless I have several days' notice.

You will be charged the full fee for sessions cancelled with less than 24 hours' notice, for other than the most serious reasons. Insurance will not cover this charge.

Fees, Payments, and Billing

Please refer to the pricing sheet provided for you.

I accept debit and credit cards, health savings account, cash, or check. Those with insurance coverage are expected to pay the co-payment or co-insurance at the time of service. If your insurance coverage is rejected, then you will be responsible for the full fee. You should call your insurance company to verify benefits, determine co-pay amounts, and get information on deductibles, prior authorization or the need for a doctor's referral.

Payment should be made when services are rendered. If you think you may have trouble paying your bills on time, please discuss this with me. If you get behind more than the cost of two sessions, I will notify you in writing. If it then remains unpaid, I must stop therapy with you. Fees that continue unpaid after this will be turned over to small-claims court or a collection service.

If there is any problem with my charges, my billing, your insurance, or any other money-related point, please bring it to my attention. I will do the same with you. Such problems can interfere greatly with our work. They must be worked out openly and quickly.

If You Need to Contact Me

I cannot promise that I will be available at all times. I do not take phone calls when I am with a client. You can always leave a message on my confidential voicemail, and I will return your call as soon as I can. Generally, I will return messages daily except on weekends and holidays.

If you have a behavioral or emotional crisis and cannot reach me, you or your family members should call the Georgia Crisis and Access Line at (800) 715-4225, or go to the nearest hospital emergency room (or dial 911).

Statement of Principles and Complaint Procedures

It is my intention to fully abide by all the rules of the Georgia Composite Board of Professional Counselors, Marriage and Family Therapist and Social Workers. Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has even broken a professional rule, please tell me. You can also contact the Georgia Secretary of State. A representative can help clarify your concerns or tell you how to file a complaint.

In my practice as a therapist, I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Our Agreement

I, the client (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the therapist, before I start (or the client starts) formal therapy. I also understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this handout, I can talk with you about them, and you will do your best to answer them.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the issues and points in this handout. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this brochure. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here. My signature below also indicates that I have been given a copy of the HIPAA Notice of Privacy Practices. My signature authorizes the release of information necessary to process health insurance claims and authorizes the payment of health benefits directly to the provider (if applicable).

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

Relationship to client:

__ Self __ Parent __ Legal guardian

_____ _____

Therapist Signature Date

If using insurance/EAP:

I understand and agree that information regarding my treatment and care may be released to my insurance/EAP company for the purpose of securing reimbursement for services rendered and continuation of therapy. This may include periodic audits of my records by the insurance company or the behavioral contract organization.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

Relationship to client:

__ Self __ Parent __ Legal guardian

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

Relationship to client:

__ Self __ Parent __ Legal guardian

Client Information

Date: _____ **Client's name:** _____
Legal Gender: Male Female **If presenting gender differs from legal please convey:** _____

Ethnicity: _____ **DOB:** _____ **Age:** _____

For children/adolescent Clients under 18, please provide the following information:

Parent/Guardian's name (if applicable): _____ **Relationship to client:** _____

If parents not married/together what is the custody agreement? Sole Joint Other:_____

(Please provide paperwork to prove legal custody)

Contact Information

Client's phone numbers: Home_____ Mobile _____ Other_____

May we call/leave message you to remind you of appointments? Yes No
May we send a text message to remind of appointments? Yes No
May we contact you by email? Yes No

Client's Address: _____City_____ State _____ Zip_____

Client/Guardian's email address: _____

Insurance Information (please fill-in information along with providing copy of card)

Insurance Plan Name: _____ **Policy number:** _____

Insurance phone numbers: _____ **Subscriber's DOB:** _____

Subscriber's name: _____ **Relationship to client:** _____

Your current employer
Employer: _____ Address: _____
Work phone: _____ Occupation: _____

Emergency Contact

Name of supportive person: _____ **Relationship:** _____

Emergency contact's phone numbers: Mobile _____ Other _____

How did you hear about Building Blocks Family Counseling?

_____

Credit Card Guaranty of Payment

I understand that my therapist will be billing me for therapy, evaluation services and or any other covered services. I further understand that I am responsible for all my fees as well as late cancellations or no-show charges.

I understand that if the bill is to be split between multiple parties for any reason, all applicable parties are required to complete this form and to maintain active credit card information on file.

I also understand that some services are not covered under insurance or that I have the option to not use my insurance. In either of these cases I agree to pay the full session fee as determined by my provider. I understand that fees are due at the time services are rendered and must be paid in full unless a payment plan has been agreed to by my provider.

I hereby acknowledge that I understand and give my therapist permission to charge my credit card for any services that have not been paid by myself. I understand that this form is valid for three years unless I cancel the authorization in writing. If I cannot provide a credit card to place on file then I agree to allow my therapist to release my demographic information to a collection agency for reimbursement if payment or balance has been outstanding for a minimum of 120 days.

Patient Name

Cardholder Name (if different from the patient)

Cardholder Billing Address

Type of Credit Card (Visa, MasterCard, Discover) CVC (security code)

Credit Card Number Expiration Date

Please sign and date below acknowledging that you have read and agree to the above policy.

Signature and Date