building blocks
Family Counseling

Main Address:
205 S. Skinner Ave. Unit B
Pooler, GA 31322
912-349-8043
info@buildingblocks.solutions
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 uses 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. You should understand these limits, so you will not think they are personal responses to you. First, your therapist's training and practice is psychotherapy—not law, medicine, finance, or any other profession. Your therapist is not able to give you good advice from these other professional viewpoints. Second, state laws and our code of ethics require your therapist to keep what you talk about confidential (that is, private). You can trust your therapist not to tell anyone else what you tell her, except in certain limited situations. (Explained in the HIPAA Notice Privacy Practices.) Therapists try not to reveal who their clients are. This is part of our effort to maintain your privacy. If we meet on the street or socially, we may not say hello or talk to you very much. The therapist's behavior will not be a personal reaction to you, but a way to maintain the confidentiality of the relationship. Third, in your best interest, and following the code of ethics, your therapist can only be your therapist. They cannot have any other role in your life. They cannot, now or ever, be a close friend or socialize with any of their clients. They cannot be a therapist to someone who is already a friend. They can never have a sexual or romantic relationship with any client during, or after, the course of therapy. They cannot have a business relationship with any of my clients, other than the therapy relationship.

About Confidentiality

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

There are two situations in which your therapist might talk about part of your case with another therapist. First, when your therapist is away from the office for a few days, another therapist in the practice would be made available for emergencies. Second, our therapists sometimes consult other

therapists or other professionals about our clients. This helps 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 your therapist must discontinue your relationship because of illness, disability, or other presently unforeseen circumstances, your therapist will ask you to agree to transfer your records to another therapist at our practice who will assure their confidentiality, preservation, and appropriate access.

There is an exception to confidentiality because of the family nature of the therapy we provide. Your therapist will not keep family secrets from family members as we think that secrets are often at the root of family problems. Your therapist will also not go behind your back. Instead, if you reveal something to your therapist that she/he feels would be something important to share with your family members she/he will talk to you about it and encourage you to disclose that information yourself, or even help you in that disclosure.

Release of Information/Records

In order to release any information or records regarding your case, we require each client to complete a release of information form. These forms can be found on our website. Please note that in the case of couples counseling, both parties are considered the client. In order to release any information, both parties would need to complete and sign a release form. In the case of therapy of a minor (with custody arrangements), *if joint custody is in place*, each parent/guardian would need to sign a release of information form for the minor child.

Consultations

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

If for some reason treatment is not going well, we might suggest you see another therapist or another professional in addition to your therapist. As a responsible person and ethical therapist, we cannot continue to treat you if the treatment is not working for you. If you wish for another professional's opinion at any time, or wish to talk with another therapist, we 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.

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 Your Appointments

The very first time you meet with your therapist, you will need to give each other mostly basic information. Therapy will usually start with a session once a week, then less often. We will reserve a regular appointment time for you into the foreseeable future. We also do this for our other patients. Therefore, we are rarely able to fill a canceled session unless we have several days' notice.

You will be charged the full fee for sessions canceled 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.

We accept debit and credit cards, health savings accounts, cash, or checks. Those with insurance coverage are expected to pay the copayment or coinsurance 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 copay 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 your therapist. **If you get behind more than the cost of two sessions, you will be notified in writing.** If it then remains unpaid, we 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 your charges, your billing, your insurance, or any other money-related point, please bring it to our attention. We 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

Your therapist cannot promise to be available at all times. We do not take phone calls when we are with a client. You can always leave a message on the confidential voicemail, and we will return your call as soon as we can. Generally, we will return messages daily except on weekends and holidays.

If you have a behavioral or emotional crisis and cannot reach the office, 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 our 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 us at once. We will make every effort to hear any complaints you have and to seek solutions to them. If you feel that your therapist, or any other therapist, has treated you unfairly or has even broken a professional rule, please tell one of us at the practice. 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 our practice at Building Blocks Family Counseling, we 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. We 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 our attention immediately.

Telehealth Treatment Consent

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding (Please initial each statement)

_____ I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

_____ I understand that telemental health services are not the best fit for everyone and there may be some reasons why my therapist can not provide telemental health services. Some of these reasons include: suicidality, lack of confidentiality during session, or previous high risk behaviors that would make telemental health service unethical or unsafe.

_____ I understand that none of the telemental health sessions will be

recorded or photographed.

_____ I agree not to make or allow audio or video recordings of any

portion of the sessions.

_____ I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

_____ I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

_____ I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

_____ I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

_____ I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

_____ I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

_____ I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

_____ I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

_____ I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand a credit card or other form of payment will be established before the first session.

_____ I understand my therapist will advise me about what telemental health platform to use and will establish a video conference session.

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 are 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

Building Blocks Fees

All fees that may apply during your treatment with our practice are listed below. All provider fees reflected below are self pay rates. If you utilize insurance for your appointments, the fee per session will vary based on your individualized insurance policy benefits.

Doctoral Level Licensed Providers	$175 per session
Master Level Licensed Providers	$150 per session
Associate Level Unlicensed Providers (Supervised)	$75 per session
Intern Providers (Supervised)	$35 per session
No Show Fee	Subject to the full fee of the session
Late Cancellation	Subject to half the fee of the session
Court/Documentation Fees	Court appearance- Session Rate x length (time) of appearance (minimum) Documentation-varies based on need Please see below for exclusions/additions

The fees outlined below are not covered by insurance and would be charged to you directly.

A **No Show** is considered to be an appointment that was scheduled and your therapist is **not** notified that you need to reschedule/cancel or an appointment that was scheduled that was not attended by the client. Each session has a 15 minute grace period following the start of the appointment to reach out to your therapist in case of emergency to notify them of the need to reschedule. **Please call or text your therapist's direct line in the case of an emergency or last minute cancellation**. If there is no communication with your therapist before the 15 minute grace period then the appointment will be automatically counted as a no show and you will need to contact your therapist directly to reschedule. Please note that each session is scheduled in a 60 minute time slot so you will only receive the designated time left in your appointment.

A **Late Cancellation** is considered to be an appointment that is canceled or asked to be rescheduled within 24 hours of the scheduled appointment.
Please make every effort to communicate with your therapist (**directly**) when needing to cancel or reschedule appointments. If late cancellations or repeated missed appointments become an issue, Building Blocks reserves the right to adjust appointment times as needed.

Court/Documentation Fees vary depending on multiple factors such as: time frame, form of documentation requested, and in person/virtual attendance or the location of appearance requested. Due

to the variation you must discuss these directly with your therapist. **Court appearances and documentation are required to be requested with a minimum of a 48 hour notice prior to needing the documentation or appearance.** An additional fee may be applied in excess of the minimum rate for rushed requests.

Building Blocks reserves the right to space out appointments or pause services to collect unpaid fees when a payment plan is not in place.