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Psychotherapy Service Agreement

Psychotherapy provides an opportunity for exploration, insight, healing, growth, and change. An optimal psychotherapy experience is grounded in the relationship that is established between the therapist and client. It is important that the conditions of this relationship are clearly outlined in order to create a consistent, stable, trusting, and safe working environment. The terms outlined below are intended to help ensure an optimal therapeutic relationship.

Nature of Counseling and Psychotherapy
I provide short-term and long-term individual, family, and couples counseling, psychotherapy, coaching, co-parent training and parenting coordination. Counseling, coaching and co-parent training are short-term and designed to address specific issues with goal-oriented solutions. Psychotherapy typically addresses deep-seated emotional wounds and is more in-depth and usually requires longer-term services. Parenting coordination is used to address higher conflict between divorced parents. The issues you identify as the target for your treatment guides and shapes which approach is best suited to effectively and appropriately meet your needs.

It is important to be aware that each of these types of psychotherapy services can be emotionally and psychologically challenging, even painful at times when sensitive issues are discussed. Sometimes, you may feel worse before you feel better. These treatments are shown to have many benefits. Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. While there is an expectation that there will be benefits from psychotherapy, there is no guarantee that this will occur. Maximum benefit will occur with consistent attendance and active participation.

Confidentiality
I agree to honor your confidentiality in all contexts for counseling and psychotherapy services. I work to maintain appropriate relationship boundaries in all settings. If I should ever find myself in a social setting where you are present (e.g., shopping mall or restaurant), I will respect your privacy by not initiating contact or seeking to engage you in a conversation unless initiated by you. Should I be accompanied by a family member or friend, I will not introduce them to you. I will also maintain appropriate professional boundaries in social media venues by not searching for you on LinkedIn, Facebook, Twitter, etc. and will ignore any and all request by current or former clients to connect on these sites.

Exceptions and limits to confidentiality are as follows:

- Georgia state law requires that mental health professionals report to the Department of Family and Children Services or the police any situation of suspected sexual, physical, or emotional abuse or neglect of a minor, disabled, or elderly person. Therefore, any disclosure made during therapy sessions of such abuses will be reported. I am committed to handling such situations in a therapeutic manner.

- Georgia state law and professional ethical standards require exception to confidentiality if there is clear indication of imminent danger of you physically harming yourself, risk of suicide or threat of harm to another person. In these cases, I will make every effort to ensure your safety by

contacting your emergency contact person, family member, or other appropriate identified person to develop a safety plan. If deemed appropriate as a last resort to ensure safety, under the provisions of my clinical social work license, I have the authority involve law enforcement and involuntarily require psychiatric hospital assessment.

- If you would like me to talk with another professional provider from whom you are receiving treatment (i.e., psychiatrist, primary care physician), you must sign a Release of Information form authorizing the terms of such professional communications. You may revoke your consent at any time.

- In keeping with generally accepted standards of practice, I frequently consult with other mental health professionals regarding management of cases. The purpose of the consultation is to ensure quality of care. I do not use identifying personal information about you as to preserve anonymity.

- If you choose use insurance benefits to pay for any cost related to your psychotherapy treatment, I am required to release requested information in order for your insurance company to process your claim. This information may include, but is not limited to, assigning a clinical diagnosis (e.g.: Major Depression, Anxiety Disorder, Alcohol Abuse, ADHD), descriptions of your problems, and reports of progress. Be advised that I have no authority or liability regarding how information is used after it is released from my control. I may, at times, hire a contracted agency to assist in carrying out medical billing processes. All such contracted agencies may have access to your personal information and adhere to the same confidentiality standards and limitations as myself.

Co-parent training and parenting coordination are not confidential services. These services are usually court ordered and disclosure of information about the progress obtained during these services is often required. Any of these services provided through The Center for Navigating Family Change is subject to the policies of said organization.

Tele-Mental Health
Tele-mental health issues include everything about how you and I interact via electronic means. Please be aware that the only truly secure means of communication is face to face interaction or via land line telephone. Our communication via cell phone, text, fax, email and video calling can not be considered completely confidential. I will only communicate with you via these methods upon your consent and will limit the nature of these communications to administrative content only unless requested by you. On occasion when appropriate, counseling services may be provided on-line via video through services such as skype. Please be aware that that skype does not meet the standard for encryption and is not considered a confidential means of communication and will only be used if requested.

Fees
The fee for an initial individual, couple, or family diagnostic assessment is $150.00 and on-going psychotherapy is $125.00 per 50-minute session. Your payment or co-payment is due at the time of each session unless other arrangements have been agreed upon in advance. A service fee of $10.00 will be added if you are unable to provide your appropriate payment on your date of service. If you would like to pay for multiple session dates at one time, you may choose to pay in advance and carry a credit balance on your account. Counseling or psychotherapy services, over 10 minutes, provided over the phone may be billed at the regular hourly rate. This charge is added to your next session fee. Time used for preparation of requested written reports or documents is billed at the session fee rate and payable upon delivery. A fee of $25.00 will be charged if a check is returned for insufficient funds. I will provide a Statement of Services or invoice upon your request. Cash, personal check, and credit/debit/HSA cards (a $4 service fee will added to electronic transactions) are accepted as payment.

Signature required on last page

The fee for co-parent training and parenting coordination is $150 per hour. Any of these services provided through The Center for Navigating Family Change is subject to the policies of said organization.

Insurance
I will directly bill your insurance company for payment upon your request and consent for insurance providers with whom I am contracted. I will provide a Statement of Service outlining dates of service, diagnostic and billing codes upon request for clients choosing to file an insurance claim for out of network treatment. While your insurance benefits may provide for payment for all or part of the fees connected with your psychotherapy, ***you are ultimately responsible for the cost for your treatment***. ***You are responsible for obtaining and up-dating/maintaining authorization for service as required by your benefit plan to ensure coverage.*** Any statement of coverage given by your insurance company is not a guarantee of payment. Your actual coverage is determined at the time the claim is filed. You are responsible for paying co-payments and co-insurance at the time services are rendered as indicated by your specific benefit plan. It is recommended that you contact your insurance company if you have any questions about your benefits and any limitations that may apply. You are responsible for payment for any services and for all amounts not paid by your insurance company, including but not limited to charges for missed appointments, appointments cancelled with less than 24 hours notice, telephone counseling, and document preparation fees.

Appointment Cancellation Policy
A scheduled appointment involves the reservation of time specifically for you. To avoid a *$50.00* charge (*which is not covered by insurance*) for a missed session or late cancellation, please inform me of your need to re-schedule your appointment at least 24 hours in advance. Leaving a voice mail message is sufficient to cancel an appointment and avoid these extra charges. The fee for a missed appointment or late cancellation is due at the next appointment. The total fee or your co-payment amount for your next appointment will be reduced by $50.00 if I need to cancel /re-schedule your appointment with less than 24 hours notice.

Legal Issues
It is important that you agree to inform me if any legal proceedings develop which might have an impact upon your therapy. Please inform me if your intention is to use this therapy as part of a legal proceeding. My fee to testify in court $1000 per day. This fee must be paid 48 hours in advance of the scheduled court date. The fee is non-refundable even if the court date is changed as I have to reserve the entire day to be available and am unable to schedule other clients for that time. Please be aware that I must release to a court of law any information required by court order. The fee for preparing your file for a subpoena is $50.00.

Client Responsibilities
You agree to participate actively in the therapeutic process by:

A. Setting and discussing realistic and concrete goals to accomplish within a mutually agreed upon time frame.

B. Working on goals and “home work” material between sessions to facilitate the change process because change often requires personal work beyond the session time. When in session, it is also important to openly talk about whatever thoughts come to mind and emotions you are experiencing during the session.

C. Discussing any questions or complaints concerning the therapeutic process.

Signature required on last page

Therapist Responsibilities
I agree to practice within my level of competence, licensure guidelines, and ethical standards of practice. If I believe that I am unable to do so, I will tell you and will provide you with appropriate referrals.

A. I am committed to promoting the principles of empowerment to help you move toward your goals for healing and change. Remember growth and healing is a process, not an event.

B. I am committed to therapeutic treatment approaches that strive to promote and maintain the highest level of functioning for you throughout the course of your therapy.

C. I am committed to answering any questions or discussing any complaints that you have concerning the therapeutic process.

Ending Therapy
I am committed to working with you as long as the therapeutic process is productive, healthy, and in your best interest. You chose to begin participating in therapy voluntarily and you may choose to discontinue therapy at any time. If you decide to terminate the therapeutic relationship, you agree to talk openly with me about your decision and inform me at least one session in advance so that we may discuss any unresolved issues to ensure you have the information you need to move forward. Additionally, it may become necessary for me to initiate termination of services because treatment goals are met or it is no longer clinically appropriate for services to continue. In such a situation, we will discuss the reasons why termination is appropriate and we will plan an appropriate termination schedule. I will provide referrals to other providers when appropriate.

Sometimes clients drift out of the treatment process. Unless we have agreed upon another arrangement, if you do not have an appointment or make contact with me for more than five weeks, I will consider this an indication that you are choosing to terminate therapy services. After five weeks, I will consider you to be an inactive client. I will gladly reinstate you back to active status when you are ready to resume regular treatment.

Change of Personal Information
Please advise me as soon as possible if you change your address, phone, insurance, employment, marital status, or any other information that relates to the therapeutic process or billing issues.

Office Hours
I am generally available in my office for scheduled appointments between 9:00 AM and 6:00 PM. I can be reached by telephone between 9:00 AM and 9:00 PM if needed in an urgent situation. Please use discretion and contact me at (404) 432-3735 after business hours only in the event of an actual emergency or when the subject of the call is time sensitive. Please leave a detailed message and your call back phone number on each message and I will respond as quickly as possible. I try to return calls within 24 hours or during the next business day.

I will inform you when I plan to be out of town and unavailable for an extended period of time. If you have an emergency during this time, please go to your nearest hospital emergency department.

Emergency Procedures
Please call 911 or go to your nearest hospital emergency room if you are experiencing a life-threatening emergency during business hours or after hours.

Signature required on last page

By signing this Psychotherapy Service Agreement, the client(s) acknowledges that he/she has received or had the opportunity to review Sherri H. Rawsthorn, L.C.S.W. ’s psychotherapy service agreement and agrees to the terms and conditions outlined herein. The client(s) acknowledges consent to treatment and has had the opportunity to ask questions and/or discuss concerns.

Client Name (please print): _____

_____

Client Signature Date

Client Name (please print): _____

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Signature Date