TRANSFORMATIONS
THERAPY OF ATLANTA

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www.transformationsatl.com

Information, Authorization and Consent to Treatment

**Please initial next to each section on this form and sign and date on the last page*

Welcome to Transformations Therapy of Atlanta! We are pleased that you have chosen our agency to help you with your clinical needs. The purpose of this form is to inform you of our policies and protocols as well as to help you greater understand what you can expect during treatment. Though we have an ethical obligation to provide this information to you, it is important that you know that we will work closely with you throughout the entire process, welcoming any feedback or suggestions you may have.

_____Services Provided
Transformations Therapy of Atlanta only offers in office psychotherapy and tele mental health services via telephone or video sessions. Due to the nature of tele mental health clients must review and sign our tele mental health consent form which details the nature of tele mental health. Individual and couples therapy are provided during the tele mental health sessions.

_____Our Approach to Treatment
Transformations Therapy of Atlanta works closely with clients to develop a treatment model that suits their individual needs. Depending on the specific needs of the client, we may employ a psychodynamic, behavioral, cognitive or dialectical approach or a combination of these modalities. Clients are always informed of the type of approach being employed during the course of treatment. The client has the right to request a different type of approach. We will only practice within our scope of expertise, skill or training and should a client prefer to employ a specific modality where the therapist is not skilled, the therapist will notify the client of this and offer to provide an appropriate referral. We believe in not only treating the surface symptoms of clients which could be emotional or behavioral or a combination of both but also in helping the client to gain a greater understanding of the underlying reasons for the emotions or behaviors.

_____Client Participation
It is our belief that therapy is most successful when the therapist and client are committed to work together as a team toward common goals. It is important that the client understand the need to be open and honest during the sessions as the therapist will only be able to use the information provided to develop a proper treatment plan. When clients withhold information related to their history, thoughts or current situations in their lives, successful outcomes can be delayed or even damaged. The greater effort placed into employing learned techniques and skills outside of therapy, the greater the chance of achieving your desired treatment goals. It should be noted that during therapeutic treatment, the client may feel worse before they actually begin to feel better. We attribute this to the process of dealing with issues that may not have been addressed for quite some time. For this reason, it is absolutely necessary for the client to be committed to the process of therapy.

_____Confidentiality
Transformations Therapy of Atlanta will take every effort to maintain confidentiality of your PHI (protected health information). Details and exclusions to this is detailed in our Notice of Privacy Practices which is required to be reviewed and signed by you. We maintain all of your clinical records in a secure HIPPA compliant database provided by WeCounsel. All of our video sessions are held via a HIPPA complaint video software provided by WeCounsel. We will only release information of your records with your consent. If we feel the need to collaborate with other professionals regarding your treatment, we will notify you and have a release of information form signed by you prior to any communication. During our

couples counseling sessions, it is understood that both partners are considered clients of the therapist, therefore all information provided by either party, even during separate sessions are considered part of the couples therapy. In other words, therapist will not withhold any information provided by one partner from the other partner.

It is understood that therapist will make every effort on her end to protect private health information during a telephone call or video session and client is expected to make every effort to maintain confidentiality of the session. Please refer to the tele mental health consent form for more details.

Your therapist may breach confidentiality if she deems you are in danger of harming yourself or others or if there is a report of abuse to an elder or to a child.

Information shared during your therapy sessions are considered 'privileged communication' and the state of Georgia often upholds this right. However, there are certain circumstances that a judge may subpoena your records at which time every effort will be made to appeal this decision. However, if law mandates even after an appeal, we must release your PHI.

It is important that the client understands and agrees to not involve their therapist in any legal matters.

_____Session Format
All sessions are held in office or via telephone or HIPPA compliant video format. Clients requesting telephone session must understand that therapist reserves the right to require video or in office sessions during the treatment process. In order to provide the most effective treatment possible, clients will not be allowed to only have phone sessions. Telephone sessions may be incorporated along with regular video or in office sessions. The cost for sessions varies, please visit our website at www.transformationsatl.com for a complete list of pricing.

_____Cancellations and No Show's
Clients are expected to provide at least a 24 hour cancellation notice prior to the time of your scheduled appointment. Cancellations received less than 24 hours of your scheduled appointment will incur a fee of $75. This fee will be charged to the credit card on file at the time of cancellation. Should the card be declined, client will not be allowed to reschedule until the balance is paid. In the event of emergent situations, therapist reserves the right to waive a late cancel; this late cancel waiver is determined by the therapist and only allowed to be applied to the client's account once. Multiple consecutive cancellations could result in termination of services, see terminations section of this form. Clients who do not call to cancel their appointment or to reschedule, will be charged a fee of $75. No Show's will not be permitted a one time waiver.

_____Emergency Situations
Transformations Therapy of Atlanta is not accessible to clients 24 hours per day. Typically, your call to your therapist should be returned within a 24-48 hour period. If it is a holiday or weekend, your call may be returned the next business day. In the case of an emergency, please call 911 or dial the Georgia Crisis and Access Line at 1-800-715-4225.

_____Professional Relationship
Your therapist will conduct themselves in a professional manner at all times during therapeutic sessions. It is expected that the client will conduct themselves in a professional manner as well. Due to the rapport and trust building involved in the disclosure of personal information during therapeutic sessions, it can be easy to misconstrue a therapeutic relationship to be a form of friendship. Your therapist cannot engage in any activities with you outside of therapy sessions, including but not limited personal phone calls or text messages, social media engagement through personal social media sites. Your therapist cannot engage in or accept any romantic gestures by the client. Your therapist cannot accept gifts from the client. The only time a therapist may have contact with you through social media is through that therapist's business social media page and all communications via that social media site must remain

professional. Should you encounter your therapist in public, they are required to keep your identity confidential by not acknowledging that they know you. However, if you initiate contact and/or communication with your therapist in a public setting, they will engage. All of the above precautions are detailed to preserve the integrity of the therapeutic relationship and avoid any conflict of interest or presentation of a dual relationship between the therapist and the client.

_____Termination of the Therapeutic Relationship
Ideally, we would like for all of our therapeutic relationships to end when the client's treatment goals are achieved. However, we understand this is not possible at all times.

Clients are able to terminate therapy at any time, they are encouraged to choose a therapist with whom they feel comfortable and able to trust. If at any time, you feel uncomfortable or unable to trust your therapist, it is highly encouraged for you to discuss these concerns with your therapist.

If you feel your therapist, is not meeting your therapeutic needs, it is encouraged for you to discuss this with your therapist to work to resolution. If no, resolution can be made, please notify your therapist as they may be able to provide you with a referral.

If you decide to terminate therapy, we ask that regardless of your reason, you communicate this with your therapist. Some therapists, may want to schedule a final session with you in which you have the option to decline.

A therapist can terminate your sessions if they feel their services and skill are not sufficient to meet your treatment needs. At this time, a referral will be made.

A therapist can terminate the session, if they evaluate the clients actions to be inappropriate and/or damaging to the therapeutic relationship (i.e., not respecting the boundaries of the therapeutic relationship). At this time, a referral will be made.

A therapist can terminate a session, if a client cancels three or more consecutive appointments or no show's to one appointment and does not respond after a follow up call made by the therapist.

Please see our telemental health consent form for more details on therapy termination for telemental health.

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Client Signature and Date

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Therapist Signature and Date

**Therapist signature indicates that this form has been reviewed with you and any questions regarding the form have been answered.*