Novo Psychotherapy, LLC

1225 Johnson Ferry Rd., Suite 170, Marietta, GA 30068
770-847-0358

AUTHORIZATION OF INFORMED WRITTEN CONSENT FOR TREATMENT

PARTICIPATION IN PSYCHOTHERAPY TREATMENT:

Therapy is a voluntary relationship between people that works in part because of clearly defined rights and responsibilities held by each person. You may withdraw from treatment at any time without penalty and the therapist, reserves the right to terminate treatment if deemed ethically or clinically necessary. As a client in psychotherapy you have certain rights and responsibilities that are important for you to know about because this is YOUR therapy, with your well-being as the goal. There are also certain legal limitations to those rights that you should be aware of. As a therapist, we have corresponding responsibilities to you.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless. Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Your provider will use the first 1-2 sessions to conduct a comprehensive intake and formulate a clinical assessment of your needs and determine, with your full participation, a treatment plan or direction for therapy. If your provider determines that you may be better served by a different provider or service, s/he will make the recommendation and provide you with alternative resources. These referrals may be used as an adjunct to therapy or as a next step for you as per my professional recommendation.

If at any time you become dissatisfied with what is happening in therapy we hope that you will talk about it with your provider, so that they may respond to your concerns. Your feedback will be taken seriously, and with care and respect. The therapeutic relationship is built on trust, respect and a commitment towards making positive change for the client. There are times when therapy may trigger unpleasant memories or feelings, but that is part of the process and any concerns for your safety or wellbeing should be discussed in session.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are considered a provider or "covered entity." Under this federal law, as a requisite to treatment, you must also read and understand my "Notice of Privacy Practices." Without your signature on both this consent form and the Notice of Privacy Practices, you cannot be treated by Novo Psychotherpy. The Notice of Privacy Practices further explains how HIPPA has impacted your right to privacy and my ability to use your mental health information for the purposes of treatment, payment, and health care operations.

RESPONSIBILITIES TO YOU AS YOUR THERAPIST:

1. Confidentiality: Our providers are committed to maintaining strict confidentiality of your therapy. We cannot and will not tell anyone else what you have discussed, or even that you are in therapy, without your prior written permission (called "authorization for release of information form"). We will not even acknowledge you if I see you outside of the therapy room, unless you first acknowledge the provider.

2. Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature

3. As the client, you control whether or not and to whom confidential information will be disclosed. If you grant permission to share information to a specific person, your provider will always act so as to protect your privacy. If there is specific information that you DO NOT want to be shared, please be detailed in the Release for Information page. You may also revoke your permission for me to share information at any time.

4. When the client is a minor, both parents (regardless of marital status or custody arrangements) have the right to be informed about their child's treatment, and family therapy is often encouraged. However, the confidences shared in individual sessions by a child or adolescent will be respected so that an effective therapeutic relationship can be established.

5. With regards to couple, family, or group therapy, each of the clients present must, in writing, waive confidentiality before any records or information can be released. As well, if you and your partner or family members decide to have some individual sessions as a part of the couple or family therapy, what you say in those individual sessions will be considered to be a part of the couple or family therapy and can and probably will be discussed in our joint sessions. Therapists cannot be secret keepers and will encourage you and work with you to share your secrets with your partner or family members.

CONFIDENTIALITY:

The following are legal exceptions to confidentiality mandated or implied by Georgia law. Your provider will inform you any time that one of these need to enacted.

1. If there is good reason to believe that you are abusing or neglecting a child, adolescent, or elder, or if you give disclose information about someone else that is doing this, your therapist must inform the Division of Family and Children Services (DFCS) by calling the GA abuse hotline at 1-855-422-4453
2. If there is good reason to believe that you are in imminent danger of harming yourself, your therapist may legally break confidentiality and call the police to have you taken to the local crisis stabilization unit. Your therapist will explore all other options with you before taking this step.
3. If there is good reason to believe that you will harm another person, your therapist may attempt to inform that person and warn them of your intentions. Your therapist must also contact the police and ask them to protect your intended victim.
4. When there is a valid court order compelling records or witness testimony. Your therapist will attempt to obtain written permission from you when possible regarding the release of these records and can also discuss obtaining a protective order to help maintain confidentiality of records. Please let your therapist know if you are in this kind of situation so that I can take the utmost care in protecting your privacy.

*HIPPA has different conditions that allow for me to share or disclose your mental health information with or without your permission (these are outlined in the Notice of Privacy Practices). I will uphold the law (state or federal) that is stricter in favor of protecting your mental health information and your right as a client receiving therapeutic services.

1. Records and Record-keeping: Your therapist will create records with a brief summary of each session (i.e., who, when, and what was discussed) called a "progress note." If your records are requested, the therapist will normally submit a summary of the record to the requesting party. You have the right to see your record at any time. If you request a copy of the record, there will be a charge of 25 cents per copied page. The physical record is the property of the counseling office and will maintain your record in a locked, secure location for a minimum of 7 years, according to GA law.

2. Diagnosis: If a third party, such as an insurance company, is reimbursing you for part of your bill, providers am normally required to provide a diagnosis in order for the third party to pay. Diagnoses are technical terms that describe the nature of your problems. All of the diagnoses come from a book titled the DSM-V, your therapist can answer any questions that you may have with regards to its descriptions.

3. Out of the office: If your therapist is going to be away from the office for an extended period of time, s/he will tell you well in advance, also provide you with the name and phone number of the therapist covering their cases. If you have an emergency in between sessions or while provider is out of town, you are first encouraged to call 911.

After–hour's emergencies: If you have an emergency after hours you must first call 911 or GA Crisis & Access Line #1800-715-4225. You may also call call Ridgeview Institute at 770.434.4567. The police will need to escort you to the crisis stabilization unit. Then you may contact your therapist and let them know where you are and how you can be reached. If you are not having an emergency, please reserve all other information for the next scheduled appointment.

YOUR RESPONSIBILITIES AS A THERAPY CLIENT:

1. You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without providing notice, you must pay for that session at our next scheduled meeting. If this happens regularly, we will discuss how it is impacting the therapy process.
2. You are responsible for making your payment at each scheduled session. Your fee is based on a 60-minute session. Please refer to the "FEE AGREEMENT" for more specific information regarding payment. You are responsible for the investment you choose to make in the therapeutic process.
3. We are in-network with various insurance providers and will submit claims on your behalf for services rendered. If you have another insurance provider and would like to utilize your out of network benefit, we will provide you with all the necessary information you will need to file your claim. Please inform your therapist if you need any other specific information that we do not automatically provide on your session receipt. All fees are due up front and it is your responsibility to find out about your insurance coverage and payments.
4. Novo Psychotherapy is not willing to have clients run a bill. If you find that you are having a hard time paying for therapy, please discuss it with your therapist. We have a percentage of slots in the practice reserved for sliding-fee schedule clients, and if one of those is open, it will be made available. If your financial circumstances improve, please let your therapist know so that s/he can make the reduced-fee slot available to someone else. Novo Psychotherapy can also provide you with other counseling agencies & resources that provide therapy at a reduced rate. Therapists cannot ethically accept barter for therapy. If you accumulate a debt and eventually refuse to pay it, therapy will be terminated and Novo Psychotherapy reserves the right to give your name and the amount due to a collection agency.

5. Email and text messaging have become a common form of communication in our culture. It is our responsibility to inform you that your confidentiality cannot be guaranteed when we communicate this way. Our computers are protected with virus protection and firewall, but communications via the Internet or via a cell phone are always vulnerable.

Statement Regarding Ethics, Client Welfare & Safety

Novo Psychotherapy assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact Shubha Swamy (e.g., Practice Owner) #770-847-0358

Please initial below, beneath the signature lines, if you wish to communicate via email, or text message. By initialing, you acknowledge that you understand the vulnerability inherent in these communications but accept that they are a way of life and are convenient ways to schedule and reschedule appointments, provide updates, journal entries, and other information that can assist you in therapy. Any communications between us will be printed and kept in your file as a part of your therapy record.

CLIENT CONSENT AND AUTHORIZATION FOR PSYCHOTHERAPY SERVICES:
I HAVE READ THIS STATEMENT, HAD SUFFICIENT TIME TO BE SURE THAT I CONSIDERED IT CAREFULLY, ASKED ANY QUESTIONS THAT I NEEDED TO, AND I UNDERSTAND THE INFORMATION OUTLINED ABOVE. I HAVE REQUESTED A COPY, IF I WISH, OF THIS AND ANY OTHER FORM I HAVE SIGNED. I CONSENT TO HAVE THE NECESSARY INFORMATION RELEASED IN ORDER FOR ME TO FILE AN INSURANCE CLAIM. I UNDERSTAND MY RIGHTS AND RESPONSIBILITIES AS A CLIENT, AND MY THERAPIST'S RESPONSIBILTIES TO ME.
WITH THIS UNDERSTANDING, I AGREE TO UNDERTAKE THERAPY WITH NOVO PSYCHOTHERAPY

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

PLEASE SIGN BELOW ONLY IF YOU AUTHORIZE COMMUNICATION VIA EMAIL OR TEXT MESSAGE:
_____

Please initial if requesting a copy of this form. _____

Parent(s) Signature (or legal custodian) if treatment is for a minor child:

_____ Date: _____

_____ Date: _____