L. Shannon Stephens, M.S., LPC, NCC

3633 Wheeler Road • Suite 100 • Augusta, GA 30909 • Phone 706.364.0252 • Fax 706.364.0269

CLIENT CONSENT FOR COUNSELING

Welcome to my counseling practice. This document contains important information about my professional services and business policies. Please read through this entire packet carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

COUNSELOR QUALIFICATIONS: I became a Licensed Professional Counselor in Georgia in 1999 and earned the National Certified Counselor credential in 2000. I have a Master of Science degree in Clinical Psychology from Augusta State University (now Augusta University). In 2012, I became certified as a facilitator for the PREPARE/ENRICH premarital counseling program. Since 1994, I have worked in in-patient hospitals and out-patient settings, including a University Counseling Center, where I gained extensive experience providing counseling services for older adolescents and adults for issues such as depression, anxiety, stress management, spirituality issues, trauma recovery, family/relationship problems, grief, divorce recovery, career and college major indecision, academic problems and premarital counseling. During my career I have taught college courses in psychology and student success. I also have experience conducting workshops and trainings on a variety of topics, such as stress management. I also provide training and supervision to new counselors seeking to earn their Georgia professional counselor license. Over the years, much of my continuing education training has focused on evidence-based therapies such as cognitive behavioral therapy (CBT), which is a therapy approach I frequently use in my counseling practice. I have also received extended continuing education training in using cognitive processing therapy (CPT), a type of cognitive behavioral therapy, which is specifically used to treat persons diagnosed with post-traumatic stress disorder.

COUNSELING SERVICES: Counseling is not easily described in general statements. It varies depending on the personalities of the Counselor and the Client, and the problems for which you are seeking assistance. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a typical medical doctor visit. Instead, it calls for an active effort on your part. For therapy to be most successful, it requires you to invest in your counseling work both during our sessions and at home. Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a commitment of time, money, and energy, so you should be very careful about the Counselor you select. If you have questions about my procedures, we should discuss them whenever they arise. If you decide you would prefer to see another Counselor or if I determine that I am not the best person to help you, I will be happy to assist you with finding another mental health professional.

PSYCHOTHERAPY COSTS: Psychotherapy sessions are generally 53 to 60 minutes in length. Longer sessions may be arranged for patients who are self-paying and not limited by session lengths allowed by their insurance plan. If this is something you are interested in, please notify me in advance of the session. The cost for a psychotherapy session is $125.00, unless there have been prior arrangements made in writing by me. There is no provision for sliding scale fees of insurance-reimbursed psychotherapy sessions or wavier of copays due to laws enacted by insurance companies. Please read the information in this packet on Billing Procedures for further information regarding insurance and cancellation policy.

CAREER, EDUCATIONAL AND PREMARITAL COUNSELING COSTS: Be advised that insurance companies often do not cover career counseling, educational counseling, or premarital counseling. If your insurance policy covers these services, the

regular rates listed above in the psychotherapy costs section apply. Some clients, particularly career counseling clients, may benefit from completing on-line assessments to assist with the counseling process. Some of these assessments may require a fee in addition to the regular session rate. These fees vary and depend on prices set by the corporations who publish the assessments. I will discuss these fees with you at the time the assessment is recommended.

If your insurance policy covers premarital counseling services, the regular rates listed above in the psychotherapy costs section apply. If your insurance policy does not cover premarital counseling services, I charge $85 for a 53-60 minute session (Initial Premarital Counseling Evaluation is $95). The PREPARE/ENRICH online assessment costs $35 per couple and will be paid directly to PREPARE/ENRICH when you log on to the website to complete the assessment. This assessment is a necessary part of the premarital counseling process. Please refer to the separate form describing the different types of counseling services I provide for additional information about the PREPARE/ENRICH premarital counseling program.

LENGTH OF TREATMENT: This depends in part on your specific needs and abilities, the goals we set together, and the involvement of your insurance company. Some Managed Care Organizations have limits on the number of sessions allowed. It is important that you know what your insurance company allows and that this be managed wisely. You have the right to terminate therapy at any time you choose. I hope that you would allow me to participate in the termination decision rather than just disappearing as this deprives us both of the opportunity for feedback and closure.

CONFIDENTIALITY: Confidentiality in the counseling process is extremely important to me. In general, the privacy of our communications is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions:

1. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
2. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, Georgia and South Carolina laws require me to file a report with the appropriate state agency.
3. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek a medical professional's assistance with hospitalization for him/her or to contact family members or others who can help provide protection.
4. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The Consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.
5. For clients under eighteen years of age, the law allows your parent/guardian access to information about your counseling with me. It is my practice to request your parent/guardian agree to receive only general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.
6. If your therapy is covered by insurance, they may request information about your condition and treatment. If your benefits are handled by a managed care company, they may require periodic information to authorize sessions. There is no confidentiality between myself and the insurance/managed care company. Once the information leaves my office, I am no longer responsible for the confidentiality of your records. If a collection agency must be used, they will receive only your name, address, and amount owed.

7. If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must upon request, furnish copies of all medical reports and bills.
8. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

COMMUNICATION POLICY: E-mail, mobile phone text messaging (SMS) and facsimile is not secure media for communicating with me about confidential counseling related issues. Therefore, confidentiality of e-mail and facsimiles cannot be guaranteed. Urgent or emergency communications should not be sent via email or fax since timeliness of response to a facsimile or email message cannot be guaranteed. Social media such as Facebook, LinkedIn, Twitter, etc. are not appropriate means of communication with me as those media may compromise your confidentiality and privacy and blur the boundaries of the professional counseling relationship. Friend or contact requests sent to me by current clients, and some former clients, will not be accepted. I do not typically communicate with patients via email since it may not be a secure and confidential means of communication. If you and I do choose to communicate via email, discussion about counseling session content or scheduling concerns should not be included. Those issues need to be discussed face to face or by phone.

EMERGENCY PROCEDURE: If you have an emergency during the day, please telephone the office, inform them that this is an emergency and I will call you as soon as I am free between client sessions. This contact will necessarily be brief and will be used to determine a course of action only. If you need of emergency assistance after hours, please call the main office number and you will be given instructions. If the emergency is critical and you are unable to reach me in a timely manner, then it is your responsibility to telephone 911 or have someone safely transport you to a hospital emergency room. When I am out of town or otherwise unavailable, I will be using the services of a colleague to handle emergency situations. Telephone calls that are not an emergency are usually returned after hours or at the latest by the following morning. Please leave a day and evening number where you can be reached. Please inform me if you are already being followed by a psychiatrist. A psychiatrist or other medical doctor is the only professional who can prescribe medications and they may be needed to assist with a hospital admission.

CLIENT RESPONSIBILITY: The following are your responsibilities as a client: If you are late for your appointment, then I reserve the right to reschedule your appointment if I believe your late arrival will inhibit my ability to provide a complete intake or counseling session or if I believe seeing you late will compromise my ability to honor my next client's appointment time. In some cases, I may be able to see you after arriving a few minutes late. But, be advised your late arrival will cause you to miss out on your complete session time. If I am late for your session, I will make the time up at the end of the hour in order to ensure you have your full session time. Please honor the 24 hour cancellation notice policy so that the time may be utilized by someone else and you are not billed for an unused hour. You are expected to pay your bill as I have financial obligations to my office, my staff, my family and myself. Talk with me if you are having difficulty with this.

- Information: The client must provide true, accurate, and complete information.
- Instructions: The client must follow instructions for treatment. The client should understand the consequences of not doing so, and if unable to comply, must inform the staff or me so that efforts can be made to help.
- Refusal of Treatment: The client and family are responsible for the outcomes if they do not follow the medical plan of treatment and discontinue treatment against advice.
- Respect and Consideration: Clients and family must show consideration for other clients and staff by helping to control noise and behaviors in the waiting room. **Cell phones are to be turned off in the waiting room**. You may step outside to use your cell phone. Clients and family must respect the property and privacy of others and the organization.
- Obligations: The client must keep appointments and fulfill financial obligations for their diagnostic and therapeutic services.
- Behavior: The client must abide by the rules and regulations of my office.

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Not all services are a covered benefit in all insurance plans. **Patients are expected to pay for any part of charges not covered by insurance.** Unless prohibited by contract, patients will be billed for any unforeseen account balances after insurance has paid. A charge of $25.00 will be assessed on all returned personal checks. Should your account be turned over to a collection agency, you will be responsible for collection fees, attorney fees, and court costs. If temporary financial problems affecting timely payment of your account should arise, we encourage you to **contact us promptly for assistance in management of your account**.

PROFESSIONAL RECORDS: The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record if you request it in writing, except in unusual circumstances that involve 1) danger to yourself and others, 2) that make reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, or 3) where information has been supplied to me confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded directly to another mental health professional. I am allowed to charge a copying fee of about $1.00 per page (and for certain other expenses). Please go to https://dch.georgia.gov/medical-records-retrieval-rates for detailed information on current Georgia law for medical record retrieval rates. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which I will discuss with you upon request.

LETTERS/DOCUMENTATION REQUESTS: I have the right to refuse writing up disability documentation, companion pet letters, disability letters for college accommodations, letters regarding your ability to work, or any letters that inform providers of your mental health history. I do not provide letters for patients I have seen less than 5 sessions. If I agree to provide documents, please know they are prepared at your expense, as they are not covered by your insurance and require me to work for you outside of your therapy session time. My rate is the same as a self-pay rate for a therapy session which is $125 per hour unless we have agreed on another rate in advance. Please speak with me about these fees during a session when possible or by phone. I do not provide letters via email request or by messages left with front office staff without speaking to me. If I am unable to assist with your documentation requests or if you are not in agreement with paying for my time spent on your behalf, you may discuss these needs with your physician instead.

AUDIO / VISUAL RECORDING: There is to be no use of any type of visual or auditory recording devices at any time without the knowledge and consent of all parties present, including the therapist.

CANCELLATION/NO SHOW POLICY: You are expected to remember your appointments whether or not you receive a reminder from our office. Appointments must be cancelled at least 24 hours prior to the scheduled time or you will be charged $75.00. If an emergency prohibits you from providing the 24 hour notice, this should be the exception rather than the rule. You may be required to provide written documentation of the emergency to prevent you from being billed.

By signing this Patient Informed Consent and Authorization as the Patient or Guardian of said Patient, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receive mental health assessment, treatment and services, from L. Shannon Stephens, M.S., LPC, NCC, for me (or my child if said child is the patient). I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my/their health insurance. Deductibles and co-payments will be made at the time services are rendered.

Patient/Custodial Parent/Legal Guardian	**Date**

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DESCRIPTION OF MY COUNSELING SERVICES

WHAT IS PSYCHOTHERAPY?

All people deal with everyday problems and challenges. Some experience extremely traumatic and painful circumstances. Often we are able to overcome these difficulties on our own or with the support of loved ones. Other times, it is helpful to seek assistance from a trained professional who offers an objective perspective. In psychotherapy, individuals have an opportunity to develop positive coping skills and identify solutions to personal problems. Clients are taught to communicate more effectively and set healthy limits in their relationships. Behaviors, decisions and ways of thinking that prevent clients from moving forward are challenged to help the client meet their counseling goals.

WHAT IS CAREER COUNSELING?

Career counseling involves gathering information about self and the work world to determine which college academic programs or professional careers might be a good match. This process includes examining interests, clarifying values, identifying skills, resolving chronic indecision, and understanding personality type. In many cases, career testing will be recommended to achieve the best possible career counseling results.

WHAT IS EDUCATIONAL COUNSELING?

This counseling service assists older high school and college students with developing effective study and time management skills. Issues such as test taking and overcoming academic anxieties are commonly addressed. Please note that educational counseling is not the same as or a substitute for academic tutoring.

WHAT IS THE PREPARE/ENRICH PREMARITAL COUNSELING PROGRAM?

The PREPARE/ENRICH program was created as a resource to help couples establish stronger relationships and get to know each other better than before: to truly understand their partner and themselves, to make difficult conversations easier, to resolve conflicts, and to bring couples closer together. The program is a proven tool, scientifically developed to help couples stimulate honest, open dialogue about difficult to discuss subjects. PREPARE/ENRICH includes an online assessment to identify your current strengths and growth areas as a couple. The online assessment will need to be completed after the 1st counseling session and at least 5 days before the scheduled date of session 2. Assessment feedback will be provided, beginning in session 2, to help you understand your results, as well as teach you important relationship skills. The average couple attends 8 sessions to complete the process. In this process, you will:

- Identify your strengths as a couple and build new ones
- Uncover stressful areas and resolve conflicts
- Comfortably discuss financial issues
- Understand and appreciate personality differences
- Strengthen your communication skills
- Explore your families of origin
- Establish personal, couple and family goals

Premarital counseling using the PREPARE/ENRICH program is not the same as in-depth marriage counseling that focuses on resolving significant marital problems. Instead, PREPARE/ENRICH will focus on creating awareness and education in the areas listed above. If I determine a couple or either partner will best benefit from participating in more in-depth marital or individual counseling, I will discuss this issue with the couple and provide a referral to a marriage and family therapist or other appropriate mental health professional. Some of the issues that may prompt a referral include alcohol/substance abuse, physical or sexual abuse, unmanaged mental health disorders (such as serious clinical depression or anxiety disorders), sexual addictions or on-going infidelity.

For couples in Georgia, completing at least 6 hours of the PREPARE/ENRICH program will qualify you for a $35 reduction in your marriage license. Completing the program also often satisfies the premarital counseling requirements for marriage in the church sanctuary. A certificate of completion will be provided upon completion of the program.

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Today's Date: _____

PATIENT INFORMATION:

First Name:_____ Last:_____ MI. ___

Address: _____
Street City State Zip

Home Phone ( ) _____ Wk Phone: ( ) _____ Cell ( ) _____

Social Security No. :_____ Sex: M_____F_____

Date of Birth: _____Age: _____ Marital Status: S ___ M____D_____

Email:_____

Family Physician: (Name, Address, & Phone):_____

Place of Employment_____ Occupation: _____

Employer's Address:_____
Street City State Zip

For Married Patients

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Social Security No. _____ Work Phone: _____

If Patient is a Minor:

Parent/Legal Guardian Name**:** _____

Social Security No.: _____ Date of Birth: _____

Address: _____
Street City State Zip

Place of Employment: _____ Work Phone: _____

Employer's Address: _____
Street City State Zip

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EMAIL AND TEXT MESSAGING CONSENT FORM

I, _____ authorize _____
(Patient printed name) (Therapist name)
to send automated appointment reminder email and/or text messages to me. I understand my Therapist is not responsible for any breach of privacy, confidentiality, or security of the emails/texts once they are received on my electronic devices. I understand the reminder system is automated and does accept reply emails/texts and is used for the sole purpose of appointment reminders. I agree to call the Clinicians Office at 706-364-0252 within regular business hours to cancel/reschedule appointments. I understand I may be charged a late cancellation/no show fee if I do not honor the 24-hour cancellation notice policy. In the case of an emergency, I agree to notify the office as soon as possible.

Contact by text messages:

- ☐ I **DO** wish to have this contact at the following phone number:

  _____

- ☐ I **DO NOT** wish to have this contact.

Contact by email:

- ☐ I **DO** wish to have this contact at the following email address:

  _____

- ☐ I **DO NOT** wish to have this contact.

_____ _____
(Patient/Custodial Parent/Legal Guardian) (Date of Signature)

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Insurance Information:

Primary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Employer:_____

Relationship to Patient: _____SS#: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Employer:_____

Relationship to Patient: _____ SS#: _____

Assignment of Insurance Benefits

For the purpose of paying all or part of the fees owed to L. Shannon Stephens, M.S., LPC, NCC for the services which have or will be rendered to the above patient, the undersigned hereby irrevocably assigns any insurance payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy, but only to the extent necessary to pay L. Shannon Stephens, M.S., LPC, NCC , as a result of rendering services to the above mentioned patient whose liability will be reduced by the amount of benefit payments received hereunder. Undersigned understands that the nature of the patient's disability may be such that no benefit payments will be payable under the policy specified above. Any fees owed by the undersigned under the terms of this agreement shall be paid in full within thirty days after billing agency unless prior arrangements have been made in writing with L. Shannon Stephens, M.S., LPC, NCC.

_____ _____

Patient/Custodial Parent/Legal Guardian Date

*****IMPORTANT INSURANCE INFORMATION*****

We do not guarantee insurance benefits or insurance payments. We also do not guarantee that a provider is in network for any patient's plan. We request all patients to contact their individual insurance company to verify benefits and provider network status before their appointment.

Please sign acknowledgement of this information.

_____ _____

Signature **Date**

L. Shannon Stephens, M.S., LPC, NCC

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Consent for Disclosure of Information to Third Party Payers (Entities that pay your claims):

The undersigned authorizes L. Shannon Stephens, M.S., LPC, NCC to release all patient information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being evaluated and treated, to the insurance company, the third party payer, or its representatives.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company or third party payer.

The undersigned understands that the information obtained by use of this "Authorization" may be used by the above mentioned insurance company or third party payer to determine eligibility for benefits under an existing policy, and further understands that information obtained by such insurance company or third party payer shall not be released to any other person unless the undersigned so authorizes.

The undersigned acknowledges that he/she may request to receive a copy of this Authorization for disclosure of information to third party payers, and that he/she may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon.

The undersigned further acknowledges that this Authorization shall be valid during the pendency of these claims.

_____ _____

Patient/Custodial Parent/Legal Guardian Date

BILLING PROCEDURES

- Appointments must be canceled at least 24 hours prior to the scheduled appointment or you will be charged a 'no-show' or late cancellation fee of $75.00.
- A charge of $25.00 will be assessed on all returned personal checks.
- Insurance will be filed for your appointments after the office has verified insurance coverage.
- Insurance deductibles, co-payments, and coinsurance amounts must be met at the time of service.
- Insurance laws have been enacted that forbid fee altering for services. If you have hardship needs, please discuss this with me during our first session.
- Statements are mailed on a monthly basis.
- I accept checks, cash, debit cards, and credit cards, Visa and MasterCard, as forms of payment.

Please direct any concerns or questions to either myself or the front office staff at 706-364-0252.

Please sign to indicate that you have read and understand my billing policies. If you do not understand, please inform me during our first session.

_____ _____

Patient/Guarantor Signature Date

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In Case of Emergency Contact:

Name:_____ Relationship: _____

Address: _____ Phone: _____

Whom may we thank for referring you to us? _____

****WOULD YOU LIKE INFORMATION RELEASED TO YOUR PRIMARY CARE PHYSICIAN?**

YES_____ (COMPLETE ALL INFORMATION BELOW – SIGN & DATE)

NO_____ (PLEASE SIGN & DATE AT THE BOTTOM)**

Client:_____ Birthdate:_____

I, _____, authorize L. Shannon Stephens, M.S., LPC

and my primary care physician Dr._____

Phone#_____Fax#_____

Address_____

_____

to exchange information regarding my mental health and/or substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care and/or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for 12 months from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my primary care physician.

Signature:_____Date:_____

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Client Information and Informed Consent for Telemental Health Treatment

Telemental health services involve the use of electronic communications (telephone, video conference, etc.) to enable therapists to provide services to individuals remotely. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are usually minor depending on the needs of the client and the care with which the technology (cell phone, tablet, computer, etc.) is utilized.

Additional Points for Client Understanding:

- I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telemental health sessions will be recorded or photographed by my therapist without my written permission, and I understand that I may not record or photograph any of my telemental health sessions without the written permission of my therapist.
- 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 because this is a technologically based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand mental health is performed over a secure a communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- I understand that there are risks from telemental health that may include but are not limited to the possibility despite all reasonable efforts by my provider: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.
- I understand that telemental health sessions will not be the same as an in-person session since I will not be in the same room as my therapist.
- I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
- I understand I am responsible for creating a safe, confidential space during sessions and I will engage in sessions in a private location where I cannot be heard or seen by others.
- I understand I am responsible for logging out or hanging up once sessions are complete.
- I understand you may contact me from a blocked number to avoid others knowing we have connected.
- I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contact. I understand that if I do not follow safety/emergency protocols, my therapist has the right to discontinue use of teletherapy to protect my safety and well-being.
- I understand that if the video conferencing or telephone connection drops while I am in a session, I will provide a phone number (see below) for follow up contact if a plan for technical failures has not already been arranged with my therapist.
- I understand that I am required to provide an emergency contact (see below) in case of an emergency.
- I understand that telemental health-based services may not be appropriate for everyone seeking therapy. In person therapy may deemed necessary by my therapist.
- I understand I may be requested to install applications specific to treatment onto my phone, tablet, or computer device. Some applications specifically interact via phone /tablet, device, etc. and have the capability to report activity, GPS location, etc.
- I understand I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
- I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the *Client Consent for Counseling* agreement. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.
- I understand that email is not an appropriate means of communicating with my therapist in the case of emergency. I understand the email address provided below is to be used for providing this form only and is not an email that is monitored by my therapist. Any email address used by my therapist to engage in video conferencing is also not meant to be used in the case of an emergency or for counseling related content to be shared. I understand that email is not a secure communication medium for sensitive/personal information. I agree to call the office for scheduling, payments, insurance questions, or supplying other information.
- I understand that it is my responsibility to call and make payment for any balance due at the conclusion of my telehealth session.

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Emergency Contact Name: _____ Emergency Contact Number: _____

CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment, please follow the same procedure you already agreed to in the *Client Consent for Counseling* documents. **As a reminder, cancellations should be made within 24 hours of your scheduled session time, unless you have a same day emergency arise.** Please call and inform our office of any same day emergencies. **If cancellation is not made within 24 hours, I reserve the right to charge a $75 fee in the same way a fee is charged for missing or late cancelling in-person sessions.**

PAYMENT FOR SERVICES

As with your in-person sessions, we will submit a claim to any insurance provider you gave us written consent to bill in your *Consent for Disclosure of Information to Third Party Payors*. Not all mental health services are a covered benefit in all insurance plans. If you are unsure of coverage, please contact your insurance company. **Patients are expected to pay for any part of charges not covered by insurance per usual procedure (i.e., copay, deductibles, etc.)**. Billing processes are the same for telemental health services as with in office visits, as outlined in the *Client Consent for Counseling* document. Self-pay arrangements already in place will remain the same for teletherapy sessions. **Please call the office to make a payment by at the conclusion of your session.**

CONSENT

I consent to engaging in telemental health as part of my treatment with L. Shannon Stephens. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Name of Patient (Print) _____ Email (Print) _____ Cell Phone _____

Signature of Patient _____ Date _____

Name of Legal Guardian [if patient under 18] (Print) _____ Signature of Legal Guardian _____ Date _____

INFORMED CONSENT FOR IN-PERSON SERVICES AND COVID

Decision to Meet Face-to-Face

There may be a need to meet in person for some or all sessions. If there is a resurgence of COVID or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for both of our well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies.

L. Shannon Stephens, M.S., LPC, NCC

3633 Wheeler Road • Suite 100 • Augusta, GA 30909 • Phone 706.364.0252 • Fax 706.364.0269

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our staff, our families, and other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each point below to indicate that you understand and agree to these actions:

- Face masks are currently optional. You may wear a mask in the office if you choose. _____
- The waiting room should be limited to patients being seen for therapy sessions. Minor patients or patients needing physical assistance may bring 1 person with them into the waiting room. Please contact the office if this creates a problem for you. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately inform me/office staff. _____
- If you or a resident of your home tests positive for the infection or have been symptomatic from COVID within the last 10 days, you will immediately let me/office staff know and we will then [begin] resume treatment via telehealth. _____
- I understand that my therapist cannot be held responsible for any exposure risks outside of the therapy office in other parts of the building or the parking lot. _____

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

If You or I Are Sick
You understand that I am committed to keeping you, me, my staff, and our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff, believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I, or my staff, test positive for the coronavirus and may have exposed you, I will notify you so that you can take appropriate precautions.

Informed Consent
This agreement supplements the general informed consent/business agreement.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient Date

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Today's Date: _____

THANK YOU *for taking the time to fill out this packet prior to the scheduled time of your appointment. Please bring this completed form with you to your appointment after having received it from the office or plan to arrive a minimum of 30 minutes early for your appointment in order to complete the paperwork in the office. This information will be used by your Counselor to provide you the best possible counseling services. If you are uncomfortable answering any of this information or have questions about this form, please leave those questions blank and your Counselor will discuss it with you. All information will be kept confidential, subject to the exceptions noted in the previous Client Consent for Counseling Form.*

PERSONAL INFORMATION FOR YOUR COUNSELOR

Full Name: _____ Preferred Name/Nickname: _____

Date of Birth: _____ Age: _____ Gender: Male Female (circle)

Ethnicity: _____ Religion/Spiritual Orientation: _____

How did you find me for therapy? _____

A. EMPLOYMENT/SCHOOL

Occupation, employer, and number of hours worked per week: _____

Highest Level of Education Achieved: _____ Are you in school/college now? Y N

Where? _____ Grade/year in school: _____ Major/program:_____

B. MARITAL/PARTNERSHIP AND HOME INFORMATION

Relationship Status: Single Committed Relationship (How long? _____) Engaged (When? _____)

Separated (When? _____) Divorced (When? _____) Married (1st marriage? Y N When? _____)

Widowed/Widower (How long? _____) Sexual orientation: _____

List your living children and their ages: _____

List any pregnancy losses or child losses: _____

List who resides with you and indicate relationship: _____
_____

C. CURRENT NEEDS /TREATMENT HISTORY

Briefly describe the reason(s) you are seeking services now. _____
_____
_____
_____

How long have you been concerned about the problems that bring you to counseling now? _____

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In what ways have you attempted to work on these problems so far? _____
_____

How much counseling or psychotherapy have you had in the past?
___ None ___ <1 month ___ 1-3 months ___3-6 months ___ 6-12 months ___More than 1 year

Describe the counseling: _____

Are you currently seeing another counselor, psychologist, or psychiatrist: Y N If yes, list name of clinician and their office contact information: _____

Family/Primary Care Physician Name: (Name, Address & Phone) _____
_____

Describe any medical conditions/health problems: _____
_____

Please list all medications (both psychiatric and non-psychiatric) you are currently taking, the dosage, and name of the physician who prescribed it:
Name: _____ Prescriber:_____ Dose: _____ Start Date: _____ Reason: _____
Name: _____ Prescriber:_____ Dose: _____ Start Date: _____ Reason: _____
Name: _____ Prescriber:_____ Dose: _____ Start Date: _____ Reason: _____
Name: _____ Prescriber:_____ Dose: _____ Start Date: _____ Reason: _____
Name: _____ Prescriber:_____ Dose: _____ Start Date: _____ Reason: _____

If you have ever taken any other medications (other than those listed above) for problems related to stress, anxiety, depression, sleep, or any other medication related to an emotional issue list name of medication(s), when you took it, the purpose of the medication, and if you found the medication helpful:_____
_____

Do you currently have suicidal feelings? _____ Have you been suicidal in the past? _____ If yes to either, please explain: _____
_____

Any past hospitalizations related to mental health, attempted suicide, or alcohol/substance abuse? Y N If yes, please explain: _____

D. SUBSTANCES

What is your history with the following substances?

Alcohol: Quantities/Frequency in Past: _____ Quantities/Frequency Now: _____

Street/Recreational Drugs (*please specify drug & frequency of use*):

Quantities/Frequency in Past: _____ Quantities/Frequency Now: _____

Nicotine: Quantities/Frequency in Past: _____ Quantities/Frequency Now: _____

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E. FAMILY/PERSONAL HISTORY:

Is there a diagnosed or suspected family history of psychological problems? Y N If yes, describe who & what problem:
_____

Did either parent have a problem with alcohol or other drugs? Y N If yes, who? _____

Are your parents still together/together at the time of their death? Y N Parents ever married? Y N If no longer together, how old were you when their relationship ended? _____

Do you believe you experienced physical abuse? Y N If yes, who was the source of the abuse and when? _____
_____

Do you believe you experienced verbal or emotional abuse (i.e., name calling, criticism, being ignored)? Y N If yes, who was the source of the abuse and when? _____

Have you had an unwanted sexual experience as a child or as an adult? Y N If yes, by whom? _____
_____ _____ How old were you? _____ Did you tell anyone? Y N

Have you ever served in a branch of the U.S. military? Y N If yes, did your service include a combat tour of duty? Y N
If yes, describe: _____

Do you experience problems related to a past very stressful event(s) that significantly impacts your quality of life? (ex., recurring nightmares, intrusive, unwanted memories, avoiding reminders of the event, re-living the event). Y N
If yes, what event(s) do you believe is the source of these problems? _____

Please describe the quality of the relationship with your mother: _____
_____

Please describe the quality of the relationship with your father: _____
_____

Please describe the quality of the relationship with a step-parent: (specify if step-mother/step-father)_____
_____

Please describe the quality of the relationship with your spouse/significant other: _____
_____

Please list ages of siblings and note the quality of your relationship: _____
_____

Please make any other comments here you wish (i.e., any strengths or unique qualities about you that could inform our work together, what you are looking for in a therapist, fears about starting therapy, your hopes for the future, etc.).
_____

_____

_____

Thank you for taking the time to fill out this information!