Child Information Form

S. Alexis Davis, MS, LPC,CPCS, Shiobhan Sheridan, MA, NCC, LPC, RPT, Jennifer Carlson, MA, LPC, Polina Harris, MS, NCC, APC, A. Rebecca Lanier, MA, APC, AMFT, Charity Livingston, MA, APC, Brenda Banks, MA, APC, L. Michael Fields, MS, LPC, Nia Young, MS, Mia Bishop, BA, Sarah Henderson, BA, Rebekah Winter, BA, Ashley Dressel, BS

This Form is Completely Confidential

Child's Name:_____ Today's Date: _____
Child's Date of Birth: _____ Age: _____ Gender Identity:_____
Home street address: _____
City: _____ State: _____ Zip: _____
Parents' Marital/Relationship Status: _____
If divorced, who has custody?_____

Current School: _____ Grade:_____
Regular Education or Special Services (please circle one). If special services, please specify:
_____
Teacher's Name(s):_____

Parent's Name:_____
Name of Employer/Occupation:_____
Education level:_____
Please indicate yes or no for each of the following to ensure we contact you appropriately:
Home phone: _____ OK to leave Voice Mail: Yes or No
Cell phone:_____ OK to leave Voice Mail: Yes or No
Work phone:_____ OK to leave Voice Mail: Yes or No
Email: _____ OK to contact via Email: Yes or No
Any additional restrictions to contact information:
_____

Parent's Name:_____
Name of Employer/Occupation: _____
Education level:_____
Please indicate yes or no for each of the following to ensure we contact you appropriately:
Home phone: _____ OK to leave Voice Mail: Yes or No
Cell phone:_____ OK to leave Voice Mail: Yes or No
Work phone:_____ OK to leave Voice Mail: Yes or No
Email: _____ OK to contact via Email: Yes or No

Any additional restrictions to contact information:
_____

Siblings and Ages:
_____
_____

Step-Parent's Name (if applicable):_____
Name of Employer/Occupation: _____
Education level:_____

Please indicate yes or no for each of the following to ensure we contact you appropriately:

Home phone: _____ OK to leave Voice Mail: Yes or No
Cell phone:_____ OK to leave Voice Mail: Yes or No
Work phone:_____ OK to leave Voice Mail: Yes or No
Email: _____ OK to contact via Email: Yes or No

Please indicate any additional restrictions to contact information:

_____

Parent's address, if different than child's address: Which parent?

_____
_____

Person responsible for billing statements and mailing address if different than child's:

_____
_____

Person(s) to notify in case of any emergency and relationship to client:

_____

Contact Information for emergency contact(s):

_____

We will only contact this person if we believe it is a life or death emergency.
Please provide your signature to indicate that we may do so:
Client Signature: _____ Date: _____

Referred by:_____
May I have your permission to thank this person for the referral?
Yes or No
If referred by another clinician, would you like for us to communicate with one another?
Yes or No If Yes, please list clinician's contact info:

_____

Please briefly describe your presenting concern(s):

_____
_____
_____
_____

What are your goals for your child's therapy?

_____
_____
_____
_____

How long do you expect your child to be in therapy in order to accomplish these goals, or at least feel like your child has the tools to accomplish them on his/her own? _____

The following information on this form will help guide treatment.

MEDICAL HISTORY:
Please explain any of your child's significant medical problems, symptoms or illnesses:

_____
_____
_____

Child's Current Medications, including over the counter and herbal remedies:

Medication:	Dosage:	Purpose:	Name of Prescribing Doctor:

Previous Medical Hospitalizations (Approximate dates and reasons):

_____
_____

Previous Psychiatric Hospitalizations (Approximate dates and reasons):

_____
_____

Have you and your child ever talked with a psychiatrist, psychologist, or other mental health professional? Yes or No If Yes, please list approximate dates and reasons for seeking services:

_____
_____

Has your child been given a diagnosis with respect to psychological or developmental concerns? Yes or No If Yes, please list below and/or describe:

_____
_____

Please check all that apply and Circle the main problem:

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Dizziness		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/ Partnership			Abdominal Distress		
Panic			Friend(s)			Diarrhea		
Fears			Co-worker(s)			Chest Pain		
Irritability			Employer			Lump in Throat		
Concentration			Finances			Sweating		
Headaches			Legal Problems			Heart Palpitations		
Loss of memory			Sexual Concerns			Muscle Tension		
Excessive worry			History of Child Abuse			Shortness of Breath		
Feeling Manic			History of Sexual Abuse			Pain in Joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting someone else			Often Makes Careless Mistakes		
Drugs			Hurting Self			Fidgets Frequently		
Alcohol			Thoughts of Suicide			Waiting Your Turn		
Caffeine			Sleeping too Much			Completing Tasks		
Frequent Vomiting			Sleeping too Little			Speaks Without Thinking		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking to Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Chills or Hot Flashes		
Blackouts			Head Injury			Hyperactive		

Family History of (Check all that apply):

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Suicide			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalizations		
Drug/Alcohol Problems			Learning Disabilities			“Nervous Breakdown”		

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

Effective 4/14/03

I. COMMITMENT TO YOUR PRIVACY: INNERACTIONS THERAPY SERVICES is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that INNERACTIONS THERAPY SERVICES maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, INNERACTIONS THERAPY SERVICES is required to ensure that your PHI is kept private. This Notice explains when, why, and how *INNERACTIONS THERAPY SERVICES* would use and/or disclose your PHI. Use of PHI means when *INNERACTIONS THERAPY SERVICES* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *INNERACTIONS THERAPY SERVICES* releases, transfers, gives, or otherwise reveals it to a third party outside of the Institute. With some exceptions, *INNERACTIONS THERAPY SERVICES* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *INNERACTIONS THERAPY SERVICES* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *INNERACTIONS THERAPY SERVICES* Please note that *INNERACTIONS THERAPY SERVICES* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *INNERACTIONS THERAPY SERVICES* has created or maintained in the past and for any of your records that *INNERACTIONS THERAPY SERVICES* may create or maintain in the future. *INNERACTIONS THERAPY SERVICES* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *INNERACTIONS THERAPY SERVICES's* Notice of Privacy Practices.

IV. HOW INNERACTIONS THERAPY SERVICES MAY USE AND DISCLOSE YOUR PHI: *INNERACTIONS THERAPY SERVICES* will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: *INNERACTIONS THERAPY SERVICES* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *INNERACTIONS THERAPY SERVICES* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *INNERACTIONS THERAPY SERVICES* will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: *INNERACTIONS THERAPY SERVICES* may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - *INNERACTIONS THERAPY SERVICES* may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that *INNERACTIONS THERAPY SERVICES* is in compliance with applicable practices and laws. It is *INNERACTIONS THERAPY SERVICES*'s practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may audited for such purposes.

3. To Obtain Payment for Treatment: *INNERACTIONS THERAPY SERVICES* may use and disclose your PHI to bill and collect payment for the treatment and services *INNERACTIONS THERAPY SERVICES* provided you. Example: *INNERACTIONS THERAPY SERVICES* might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. *INNERACTIONS THERAPY SERVICES* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *INNERACTIONS THERAPY SERVICES's* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *INNERACTIONS THERAPY SERVICES* will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to *INNERACTIONS THERAPY SERVICES* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *INNERACTIONS THERAPY SERVICES* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *INNERACTIONS THERAPY SERVICES.*

Note: Georgia and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *INNERACTIONS THERAPY SERVICES* may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – INNERACTIONS THERAPY SERVICES may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, *INNERACTIONS THERAPY SERVICES* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *INNERACTIONS THERAPY SERVICES* may make a disclosure to the appropriate officials when a law requires *INNERACTIONS THERAPY SERVICES* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *INNERACTIONS THERAPY SERVICES* may disclose information about you to respond to a court or administrative order or a search warrant. *INNERACTIONS THERAPY SERVICES* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *INNERACTIONS THERAPY SERVICES* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** *INNERACTIONS THERAPY SERVICES* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *INNERACTIONS THERAPY SERVICES* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *INNERACTIONS THERAPY SERVICES* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *INNERACTIONS THERAPY SERVICES* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *INNERACTIONS THERAPY SERVICES* may provide PHI to law enforcement

personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

6. **Minors:** If you are a minor (under 18 years of age), *INNERACTIONS THERAPY SERVICES* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *INNERACTIONS THERAPY SERVICES* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *INNERACTIONS THERAPY SERVICES* has a reasonable suspicion of child abuse or neglect, *INNERACTIONS THERAPY SERVICES* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *INNERACTIONS THERAPY SERVICES* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *INNERACTIONS THERAPY SERVICES* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *INNERACTIONS THERAPY SERVICES* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *INNERACTIONS THERAPY SERVICES* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, *INNERACTIONS THERAPY SERVICES* may release PHI about you as required by military command authorities. *INNERACTIONS THERAPY SERVICES* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *INNERACTIONS THERAPY SERVICES* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *INNERACTIONS THERAPY SERVICES* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *INNERACTIONS THERAPY SERVICES* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *INNERACTIONS THERAPY SERVICES* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *INNERACTIONS THERAPY SERVICES* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *INNERACTIONS THERAPY SERVICES* may disclose health information to a health oversight agency for activities such as

audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *INNERACTIONS THERAPY SERVICES*'s compliance with HIPAA regulations.

17. **If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, *INNERACTIONS THERAPY SERVICES* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *INNERACTIONS THERAPY SERVICES* in writing of your decision. You understand that *INNERACTIONS THERAPY SERVICES* is unable to take back any disclosures it has already made with your permission, *INNERACTIONS THERAPY SERVICES* will continue to comply with laws that require certain disclosures, and *INNERACTIONS THERAPY SERVICES* is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in *INNERACTIONS THERAPY SERVICES*'s possession, or to get copies of it; however, you must request it in writing. If *INNERACTIONS THERAPY SERVICES* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *INNERACTIONS THERAPY SERVICES* within 30 days of receiving your written request. Under certain circumstances, *INNERACTIONS THERAPY SERVICES* may feel it must deny your request, but if it does, *INNERACTIONS THERAPY SERVICES* will give you, in writing, the reasons for the denial. *INNERACTIONS THERAPY SERVICES* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than $.25 per page and the fees associated with supplies and postage. *INNERACTIONS THERAPY SERVICES* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *INNERACTIONS THERAPY SERVICES* limit how it uses and discloses your PHI. While *INNERACTIONS THERAPY SERVICES* will consider your request, it is not legally bound to agree. If *INNERACTIONS THERAPY SERVICES* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that *INNERACTIONS THERAPY SERVICES* is legally required or permitted to make.

18. **3. The Right to Choose How INNERACTIONS THERAPY SERVICES Sends Your PHI to You:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *INNERACTIONS THERAPY SERVICES* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *INNERACTIONS THERAPY SERVICES* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

INNERACTIONS THERAPY SERVICES will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *INNERACTIONS THERAPY SERVICES* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a

reasonable sum based on a set fee for each additional request.

5. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *INNERACTIONS THERAPY SERVICES* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *INNERACTIONS THERAPY SERVICES's* receipt of your request. *INNERACTIONS THERAPY SERVICES* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *INNERACTIONS THERAPY SERVICES* denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *INNERACTIONS THERAPY SERVICES's* denial will be attached to any future disclosures of your PHI. If *INNERACTIONS THERAPY SERVICES* approves your request, it will make the change(s) to your PHI. Additionally, *INNERACTIONS THERAPY SERVICES* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *INNERACTIONS THERAPY SERVICES's* Director and Privacy Officer, _____, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision *INNERACTIONS THERAPY SERVICES* made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. *INNERACTIONS THERAPY SERVICES* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature below indicates that you Acknowledge receipt of this Notice:

_____

Client Name (please print)

_____

Client Signature Date

If Applicable:

_____

Parent/Legal Guardian Name (please print)

_____

Parent/Legal Guardian Signature Date

Date of Last Revision: 8/4/2010

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

We are very pleased that you have selected us to be your psychotherapists, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment. 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 us is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Factors in Therapy & Treatment

The success of treatment is affected by many factors. The severity of the problem, the match between therapist and client, the motivation of the client, and various other factors, effect the length of treatment. Please discuss with us your feelings about treatment and whether it is meeting your needs. Typically the decision to terminate therapy is made by mutual consent of the therapist and the client. In the event that you decide to discontinue treatment without notifying your therapist, it is our policy to assume that the therapeutic relationship will terminate 30 days after your last visit.

Confidentiality & Records

Your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our office. Additionally, we will always keep everything you say completely confidential, with the following exceptions: (1) you direct us to tell someone else and you sign a "Release of Information" form; (2) We determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) We are ordered by a judge to disclose information. In the latter case, our license does provide us with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Confidentiality & Technology

You may want to communicate with your therapist using e-mail as it is sometimes more accessible and convenient than speaking in-person or by phone. You are welcome to do so; however, please be informed that the security of email cannot be guaranteed. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by parties other than the intended recipient. We encourage you to consider the information you choose to

Please initial that you have read this page _____ _____
Client Therapist

send in an email, especially if it contains PHI. If you chose to use email as a primary means of communication, we suggest the use of an email encryption service.

Generally we do not communicate via text unless it concerns scheduling matters, as the security of SMS messaging cannot be guaranteed. If you choose to send your therapist a SMS message please be aware that the security of confidential information contained within the message cannot be assured.

Court Testimony

We are not trained in matters that involve the legal system and cannot make any recommendations regarding custody cases. We ask all our clients to waive the right to subpoena us to court. This is a policy we set in order to preserve the efficacy and integrity of our therapeutic progress and relationship with you and/or your child(ren). An appearance in court by your therapist can damage the therapist-client relationship and it is our ethical duty to make every reasonable effort to promote the welfare, autonomy, and best interest of our clients. By signing this agreement you are waiving the right to have us subpoenaed and agreeing in fact not to have my records or me subpoenaed.

In the case that we are subpoenaed to appear in court even with this waiver – whether we testify or not – we charge our full standard fee for court-related work of $500/hour of our professional time. Any of our time dedicated to any court-mandated appearances including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the courthouse in addition to time on the stand as well as any travel time will be billed at $500 per hour.

Divorce & Custody Cases

Due to the sensitive nature of divorce and all potential issues that may arise in such cases the following policies have been adopted:

- If we are meeting with a child whose parents are in the process of divorce or who are already divorced, we require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session.
- We will need to have contact with the parent who has legal custodial decision making for medical issues before we see the child for counseling.
- We will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.
- We will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child we are meeting with for counseling and will offer and encourage opportunities for both parents to participate in parent consultations throughout the course of therapy.

Please initial that you have read this page _____ _____
Client Therapist

Structure & Cost of Sessions

We agree to provide social skills evaluations and initial intake sessions for the fee of $185 per 75-90 minute sessions, psychotherapy for the fee of $150 per 60-minute session, $140 per 50-minute session, $75 per 30-minute session, $110 per therapeutic gaming group session, and $70 per 60-minute group therapy session, unless otherwise negotiated by you and your therapist. If your therapist deems it is appropriate to utilize telemental health services for sessions, you will be billed at the same rate as in-person sessions listed above. Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed as phone consultations. The fee for a 10-30 minute phone consultation is $75, and the fee for a 30-60 minute phone consultation is $150. The fee for each session will be due at the conclusion of the session.

Cash, personal checks, and all major credit cards are acceptable for payment. Please note that there is a $25 fee for any returned checks.

In the event that your outstanding balance reaches or exceeds $200, your upcoming sessions will be on hold until a payment is made and a payment plan with the Director is created. In the event that a reduced fee is needed, the Director may authorize a payment plan or provide recommendations for a different type of service or service provider.

Insurance companies have many rules and requirements specific to certain plans. It is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company upon request and to assist you with any questions you may have in this area.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify us **at least 24 hours** in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

In Case of an Emergency

Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We are not a 24-hour facility and we are not available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 48 business hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/Georgia Crisis and Access Line (GCAL): 1-800-715-4225
- Call Ridgeview Institute at 844-350-8800
- Call Peachford Hospital at 770-455-3200
- Call Lifeline (National Crisis Line) at 800-273-8255
- Call 911
- Go to the emergency room of your choice

Please initial that you have read this page _____ _____

Client Therapist

Professional Relationship

Psychotherapy is a professional service we will provide to you and/or your child. Because of the nature of therapy, your relationship with us 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 we were tointeract in any other ways, we would then have a "dual relationship," which could prove to be harmful to you and/or your child 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 interests might not be put first. In order to offer all of our clients the best care, our judgment needs to be unselfish and purely focused on your needs. This is why your relationship with us must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you and/or your child. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as we would like to, for your confidentiality we will not address you in public unless you speak to us first. We also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, we will not be able to be a friend to you like your other friends. In sum, it is our duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

We assure you that our services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that we are not performing in an ethical or professional manner, we ask that you please let us know immediately. If we are unable to resolve your concern, we will provide you with information to contact the Georgia professional licensing board that governs our profession.

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, with your participation, we will work to achieve the best possible results for you and/or your child(ren). Please also be aware that changes made in therapy may affect other people in your and/or your child(ren)'s life. For example, an increase in assertiveness may not always be welcomed by others. It is our intention to help you and/or your child(ren) manage changes in your/his/her/their 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 and/or your child(ren) begin discussing certain sensitive areas of your life. However, a topic usually is not sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you/your child(ren) and we are able to target specific treatment needs and the particular modalities that work the best for you/your child, help is generally on the way.

Please initial that you have read this page _____ _____

Client Therapist

We are sincerely looking forward to facilitating you and/or your child(ren) on the journey toward healing and growth. If you have any questions about any part of this document, please ask. Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with us as your therapists, and you are authorizing us to begin treatment with you/your child(ren).

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Please initial that you have read this page _____ _____

Client Therapist

INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

Thank you so much for choosing the services that we provide. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate HIPAA-compliant technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers" (Georgia Code 135-11-.01).

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, all therapists have completed specialized training in TeleMental Health. We have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. **Telephone conversations (other than just setting up appointments) are billed at our hourly rate.**

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see

1640 Powers Ferry Road
Bldg 2, Suite 150
Marietta, GA 30067
(770) 726-9624

9810 Medlock Bridge Rd
Bldg B, Suite 101
Johns Creek, GA 30097
(770) 680-4732

who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. **Telephone conversations (other than just setting up appointments) are billed at our hourly rate.** Additionally, we keep your phone number in our cell phone, but it is listed by your initials only and our phone is password protected. If this is a problem, please let us know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations and troubleshooting telemental health sessions.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. **You also need to know that we are required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.**

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. **You also need to know that we are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.**

We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely manner. Instead, please see below under "Emergency Procedures."

Google, Bing, etc.:

It is our policy not to search for our clients on Google, Bing or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself with us as you feel appropriate. If there is content on the Internet that you would like to share with us for therapeutic reasons, please inform us of this material and bring it to your session.

Social Media Content and Blogs:

We may post therapeutic content on our professional blog and professional social media accounts. If you have an interest in following our blog and other social media platforms, please feel free to do so. However, please be mindful that the general public may see that you

Please initial that you have read this page _____ _____
Client Therapist

are following Inneractions Therapy Services' blog and social media accounts. Once again, maintaining your confidentiality is a priority. Furthermore, please be aware that different social media platforms have the capacity for you to message, comment, or share our content. However, we utilize our social media platforms and blog as a means to share information and content with the general public rather than as a means to communicate with direct questions. We encourage you to contact your provider directly if you have questions about your sessions rather than via our professional social media accounts. Additionally, if you have questions about billing or general office questions, we encourage you to contact the office phone or email at billing@myinneractions.com or info@myinneractions.com, respectively. If you are experiencing an emergency or crisis, please contact 911 or your nearest emergency facility rather than contact us via social media.

Video Conferencing (VC)

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. We utilize DOXY.me, Google Meet, and other HIPAA-compliant video conferencing platforms. These VC platforms are HIPAA-compliant to the federal standard, HIPAA compatible, and have a signed HIPAA Business Associate Agreement (BAA). The BAA means that the video platforms are willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, your therapist will inform you of the specific platform they will use and send directions regarding how to log-in securely. At times, we may use different video platforms due to difficulties with connection and service. We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Faxing Medical Records:

If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of PHI to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. When we fax information to the authorized entity, we utilize a fax cover page to reduce the likelihood of PHI from being viewed by unauthorized entities. Furthermore, we specify who the PHI is being sent to on the fax cover page for your protection. Additionally, information that has been faxed may also remain in the hard drive of our fax machine, such as the fax numbers of recipients. However, our fax machine is kept behind two locks in the office. And, when our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Please initial that you have read this page _____ _____
Client Therapist

Recommendations to Websites or Applications (Apps):

During the course of our treatment, we may recommend that you visit certain websites for pertinent information or self-help. We may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you have visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that we do not make these recommendations. Please let your therapist know if you do not wish to utilize these adjunct services to your treatment.

Electronic Transfer of PHI for Certain Card Transactions:

We utilize Converge as the company that processes your card information. This company may send the card-holder a text or an email receipt indicating that you used that card for our services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the card-holder has the automatic receipt notification enabled to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your card's billing statement. The name on the charge will appear as Inneractions Therapy.

We accept all major credit cards and can accept some HSA, FSA, and YSA cards. At times, your card provider may flag your charge with us as unauthorized activity due to certain security measures in place, such as flagging any first time online card transactions. When this occurs, it is your responsibility to communicate with your card provider. Additionally, some HSA, FSA, and YSA providers need documentation detailing the nature of your therapy services before they will authorize these cards to process. Upon request, we can create a billing statement with our business information and description of the services rendered for you to present to your card company. Please contact the billing department at billing@myinneractions.com or 770-726-9624 with these requests.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Please initial that you have read this page _____ _____
Client Therapist

1640 Powers Ferry Road
Bldg 2, Suite 150
Marietta, GA 30067
(770) 726-9624

9810 Medlock Bridge Rd
Bldg B, Suite 101
Johns Creek, GA 30097
(770) 680-4732

Communication Response Time

We are required to make sure that you are aware that we are located in the Southeast and we abide by Eastern Standard Time. Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We are not a 24-hour facility nor are we available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. We will return phone calls, texts, and emails within 48 business hours. However, we do not return on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from us, but do one or more of the following:

- Call Behavioral Health Link/Georgia Crisis and Access Line (GCAL): 1-800-715-4225
- Call Ridgeview Institute at 844-350-8800
- Call Peachford Hospital at 770-455-3200
- Call Lifeline (National Crisis Line) at 800-273-8255
- Call 911
- Go to the emergency room of your choice

Emergency Procedures Specific to TeleMental Health Services

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and that TeleMental Health services are not appropriate.
- We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above.

Please initial that you have read this page _____ _____
Client Therapist

1640 Powers Ferry Road
Bldg 2, Suite 150
Marietta, GA 30067
(770) 726-9624

9810 Medlock Bridge Rd
Bldg B, Suite 101
Johns Creek, GA 30097
(770) 680-4732

Please list your ECP here:

Name: _____

Phone: _____

- You agree to inform us of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform us of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

  Hospital: _____

  Phone: _____

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you and that we have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call us. If we are on a phone session and we get disconnected, please call us back or contact us to schedule another session. If the issue is due to *our* phone service, and we are not able to reconnect, we will not charge you for that session.

Structure and Cost of Sessions

We offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, we may provide phone, email, or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you.

The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described in the general "Information, Authorization, and Consent to Treatment." We require a card on file ahead of time for TeleMental Health therapy for ease of billing. Please sign the Payment Document, which was sent to you separately and indicates that we may charge your card without you being physically present. Your card will be charged at the conclusion of each TeleMental Health interaction. **This includes any therapeutic interaction other than setting up appointments.** Visa, MasterCard, Discover, or American Express are acceptable for payment, and we can utilize HSA, FSA, and YSA cards upon authorization from your provider. We will provide you with a statement of the services that we provided, upon request.

Please initial that you have read this page _____ _____

Client Therapist

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. **Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for TeleMental Health services.** As stated above, we will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, **you must notify us at least 24 hours in advance**. **If such advance notice is not received, you will be financially responsible for the session you missed.** Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, we might not see a tear in your eye. Or, if audio quality is lacking, we might not hear the crack in your voice that we could easily pick up if you were in our office.

There may also be a disruption to the service (e.g., phone call disconnects or our internet connection lags). This can be frustrating and interrupt the normal flow of personal interaction. Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and we strongly encourage you to let us know if something we have done or said has upset you. We invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face Initial Meeting Preference

If we agree that TeleMental Health services are the **primary** way we choose to conduct sessions, we prefer for the initial meeting to take place in person at our therapy office. If that is not possible, we can utilize video conferencing as described above. During the initial session, we will require you to show a valid picture ID and another form of identity

Please initial that you have read this page _____ _____
Client Therapist

1640 Powers Ferry Road
Bldg 2, Suite 150
Marietta, GA 30067
(770) 726-9624

9810 Medlock Bridge Rd
Bldg B, Suite 101
Johns Creek, GA 30097
(770) 680-4732

verification such as a credit card in your name. **This procedure prevents another person from posing as you.**

Consent to TeleMental Health Services

The TeleMental Health services you are authorizing us to utilize for your treatment or administrative purposes are listed below. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying us in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to our practice, and we will be utilizing that technology unless otherwise negotiated by you.

- ❑ Email
- ❑ Video Conferencing
- ❑ Recommendations to Websites or Apps

Please initial that you have read this page _____ _____
Client Therapist

1640 Powers Ferry Road
Bldg 2, Suite 150
Marietta, GA 30067
(770) 726-9624

9810 Medlock Bridge Rd
Bldg B, Suite 101
Johns Creek, GA 30097
(770) 680-4732

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Please initial that you have read this page _____ _____
Client Therapist

1640 Powers Ferry Road
Bldg 2, Suite 150
Marietta, GA 30067
(770) 726-9624

9810 Medlock Bridge Rd
Bldg B, Suite 101
Johns Creek, GA 30097
(770) 680-4732

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Inneractions Therapy Services, LLC has put in place preventative measures to reduce the spread of COVID-19; however, we **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments with Inneractions Therapy **could increase** your risk and your child(ren)'s risk of contacting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments with Inneractions Therapy and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Inneractions Therapy may result from the actions, omissions, or negligence of myself and others, including, but not limited to Inneractions Therapy, their contractors, Interns, volunteers, and other participants and their families.
I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments with Inneractions Therapy. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmlessInneractions Therapy, its contractors, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Inneractions Therapy, its contractors, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments with Inneractions Therapy Services LLC.

_____
Printed Name of Client

_____ _____
Signature of client/parent Date

_____ _____
Therapist signature Date

As a convenience to you, Inneractions Therapy Services is pleased to offer many forms of payment. Thank You.

Date: **Client's Name:**

Type of Payment

___Cash ____Check ____Card ___3rd Party Payer

Type(s) of Service

Intake Session Staff Therapist ($185)
Intake Session Intern ($75)
Individual or Family Staff Therapist (60min $150, 45min $140, 30min $75)
Individual or Family Intern (60min $65, 30min $35)
Group Therapy ($70 a session)
Therapeutic Gaming Group Therapy- 2 hour/biweekly ($110 a session)

Billing Statements

Inneractions Therapy Services is happy to provide you with billing statements for your services rendered and payments received. Please specify if you wish to receive these statements and the frequency and delivery of retrieval.

Receive Statements: YES or NO

Delivery of Statements: Electronically via email or physically mailed

Email or Physical Address: _____

Frequency of Delivery: Quarterly or Monthly or Weekly

Payment Authorization

I understand the above mentioned payments for services, and I understand it is my responsibility to provide payment for sessions. I understand that billing is processed weekly unless otherwise stated in a payment plan approved by the Director. I understand that if my balance owed total reaches or exceeds $200, my sessions will be on hold until an approved payment is made or an approved payment plan is approved by the Director.

Your Signature: _____ **Date:** _____

Therapist's Signature: _____ **Date:** _____

Director's Signature: _____ **Date:** _____

Card Authorization Form

I authorize Inneractions Therapy Services, LLC (ITS) to charge my card. I authorize ITS to release my name, my child's name, billing information, reason for dispute or claim, and any clarifying documentation such as initialed and signed informed consent documentation, communication with Elavon/Virtual Merchant/Converge, email correspondence, and/or phone consultations to Elavon and Virtual Merchant, ITS' credit card processing service, in the event of a financial dispute or financial clarification.

Your Signature:_____ **Date**:_____

Card Type (please circle): VISA MASTERCARD DISCOVER AMEX HSA FSA
Card Number:_____
Name as it appears on the card:_____
Phone number of Person Responsible for Billing:_____
Expiration date:_____
CVV (3 digit code on the back of your card):_____
Billing Address and Zip :_____

Please check one:

_____Inneractions Therapy Services is authorized to charge my credit card for any current balances as well as any future charges as they are incurred.

_____Inneractions Therapy Services is authorized to charge my credit card one time in the amount of_____.

Client Name: _____ **Date**: _____

Your Signature: _____ **Date**: _____

Therapist's Signature: _____ **Date**: _____

Director's Signature: _____ **Date**: _____

S. Alexis Davis, MS, LPC, Shiobhan Sheridan, MA, NCC, LPC, RPT, Jennifer Carlson, MA, LPC, Polina Harris, MS, NCC, APC, A. Rebecca Lanier, MA, APC, AMFT, Charity Livingston, MA, APC, Brenda Banks, MA, APC, L. Michael Fields, MS, LPC, Nia Young, MS, Mia Bishop, BA, Sarah Henderson, BA, Rebekah Winter, BA, Ashley Dressel, BS
1640 Powers Ferry Road, Building 2, Suite 150, Marietta, GA 30067
9810 Medlock Bridge Rd, Building B, Suite 101, Johns Creek, GA 30097

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in yourchild's therapy, and you believe it would be helpful for your therapist to contact them regarding treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your child's treatment process. Information shared is for the sole purpose of facilitating maximum care to your child as the client. Please provide the necessary information and your signature with today's date as indicated below.

****

I, _____ (parent/guardian), hereby authorize S. Alexis Davis, MS, LPC/ Shiobhan Sheridan, MA, NCC, LPC, RPT/Jennifer Carlson, MA, LPC/Polina Harris, MS, NCC, APC/A. Rebecca Lanier, MA, APC, AMFT/Charity Livingston, MA, APC/Brenda Banks, MA, APC/L. Michael Fields, MS, LPC/Nia Young, MS/ Mia Bishop, BA/Sarah Henderson, BA/ Rebekah Winter, BA/ Ashley Dressel, BS and the following party or parties to discuss my or my child's mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis.

(1) _____

(2) _____

(3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my child's medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____

_____

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist to be effective.

Client's Name:_____

Parents Name: _____

Client/Parent's/Legal Guardian's Signature:_____ Date: _____