George W. Rinker, MS, MDiv.

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Confidentiality, Disclosures and Consent for Treatment

Theoretical Views & Client Participation:

I am very pleased that you have selected me to be your Professional Counselor, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment.

Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role, both during and between sessions. This also means avoiding any mind-altering substances including but not limited to alcohol and non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by

others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Limits of Confidentiality:

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to harm another person(s), including murder, assault or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings and sexual abuse.
4. The client reports abuse of the elderly.
5. In the case of court ordered reporting for which the therapist is selective about disclosure.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communications between the therapist and client will otherwise be deemed confidential as stated under the laws of this state.

HIPPA Federal Laws:

Patient Consent to the Use and Disclosure of Health Information for treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, George W. Rinker, MDiv., MS, LPC originates and maintains paper and/or electronic records describing my health history, symptoms, diagnosis and test results, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***HIPA Notice of Privacy Policy*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and

- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that George W. Rinker, MDiv., MS, LPC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I furthermore understand that George W. Rinker, MDiv., MS, LPC reserves the right to change their notice and practices in accordance with section 164.520 of the Code of Federal Regulations. We will provide you with a copy of the most recent version of the Privacy Policy at any time upon written request to our Privacy Officer, George W. Rinker, MDiv, MS, LPC, 2801 Buford Highway, Suite 501, Atlanta, Georgia 30329, or at your next visit.

I wish to have the following persons/organizations to receive information of my counseling information:

Names: Phone:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or email to the above listed.

I fully understand and **accept** the terms of this consent.

Client Emergency Plan:

Your therapist is accessible via telephone, email and voice mail. Messages are retrieved and returned daily, whenever possible, Monday through Thursday. Messages left on Fridays are returned on the following Monday. This office is not equipped to provide 24-hour emergency service. In the event that you experience a mental health crisis and your therapist is not reachable by phone you will need to contact Dekalb County Mental Health at (404) 892-4646, Gwinnett County Mental Health at (770) 9638141, Fulton County Mental Health at (404) 730-1600, the United Way at 211, Ridgeview Institute at 770-434-4567 or Peachford Hospital at 770-454-5589, emergency services at 911 or report to the nearest Hospital Emergency Room for immediate assistance.

Technology Statement:

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me to maintain your confidentiality, respect your boundaries, and ascertain that our relationship remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for me not to use a cell phone when contacting you, please let me know.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. If you choose to utilize texting or email, please discuss this with me.

However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality.

I agree to brief: **Cell/phone calls**:_____ (initial) **Texts**:_____ (initial) **Emails**:_____ (initial)

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

Phone Counseling Sessions: (Optional)

I acknowledge that Counseling sessions by phone, Facetime or Skype are totally optional and sometimes helpful in the case of situations of traveling, distance or life events that may arise preventing my attendance at the Counseling Office for a scheduled appointment. I understand that confidentiality may **NOT** be guaranteed when using technology as stated above in the Technology Statement. By signing here I give permission to use technology as in phone or skype when needed and understand the ramifications of such methodology for Counseling Sessions. Furthermore, I may terminate the use of such technology methods by presenting my written desire to stop such methods, signed and dated as to when such methods would stop.

By signing here I am agreeing to use Technology for Counseling Sessions should the need arise.

Signed:_____ Dated_____

Phone Number to be used:_____ Email to be used:_____ I am also in agreement to using Skype: _____ (initial) Facetime:_____(initial)

Note: Termination of this release of Phone/Skype/Facetime Counseling Sessions may be granted at any time I choose but must be done in writing to: George W Rinker, MS, MDiv., LPC

Informed Consent for Telebehavioral Health

Telebehavioral Health involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information or conduct online counseling sessions for the purpose of improving patient care. As with any medical procedure, there are potential risks associated with the use of Telebehavioral Health. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the counselor.
- Delays in treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telebehavioral Health, and that no information obtained in the use of Telebehavioral Health which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telebehavioral Health in the course of my care at any time in writing.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding Telebehavioral Health and I hereby authorize George W Rinker, LPC to use telemedicine in the course of my counseling.

_____ _____

Signature **Date**

Client Responsibilities:

- Be on time for your scheduled sessions. Payment for service is due at each session.
- Give 24-hour notice of cancellation of a scheduled appointment or there will be a full Session $175 fee charged me.
- If an appointment is not kept and the client desires to continue therapy, I will call my therapist to schedule another appointment or all future appointments may be canceled.
- Follow the plan of therapy as set forth in your therapy sessions.
- Inform your therapist of any concerns regarding treatment, payment of services, desire to terminate services, job/salary, or any changes affecting therapy.
- Currently, I accept cash, personal check, Zelle and Venmo as forms of payment. And do NOT accept any charge cards or debit cards.

Third party Payment for Client Services: (optional)

I_____ acknowledge that all or a portion of my counseling services are being paid by a Third Party_____, relationship _____. In so doing I understand that the Counselor, George W. Rinker, MS, LPC will have to bill and correspond (email, text or phone conversation) with the Third Party in order to receive payment for my Counseling Services. Correspondence may include a very general indication that I am attending my scheduled sessions, I am complying with my plan of therapy and generally that I am doing well. Details of my confidential counseling sessions will not be disclosed only information pertaining to payment and attendance on my behalf. My Third Party payer may be reached at: _____ (phone) _____ (email). If I choose to terminate this agreement of Third Party Payment I will present it to my Counselor in Writing, Signed by me and Dated as to when this agreement is terminated. I agree:_____ (initial)

Consent to Treatment and Fee Agreement:

- I voluntarily choose to participate in psychotherapy at this time and I understand that I may terminate my therapy at any time without penalty.

- I have read the "Limits of Confidentiality" provided to me. I understand that I have a right to confidentiality in therapy and that information about me or my therapy may not be released to another party without my written permission. I understand the limitations of confidentiality regarding situations in which I or another person could be harmed, suspected neglect or abuse of a child or vulnerable adult, court order, professional consultation, and other exceptions as noted in this form.

- I understand the terms of HIPP the Federal Law that protects my Medical/Psychological Records.

- I have read and understand the terms of fees and payments for my counseling services and agree to the terms therein. I agree to pay George W. Rinker, MDiv., MS, LPC $175 for a 50-minute session and am subject to the payment of a full session without 24-hour notice of cancellation. _____ (Initial)

- If I choose to use my out-of-network insurance, I understand that it is my responsibility to bill my insurance company myself and the practice of George W. Rinker, MDiv., MS, LPC does not correspond with the insurance industry in any way. I agree to pay full fee for my therapy at the time of service. I will arrange for my insurance company to direct reimbursement to me directly. _____ (initial)

- I have read, understand and agree to all of the terms and disclosures in this document and give my full consent to be engaged in the counseling process with George W. Rinker, MS, LPC, knowing that I may be subject to the emotional distress, pain and hard work of the issues that I bring to this therapy process. I agree to make payment at the time of services as outlined and comply with the treatment plan prescribed me. I agree to all terms in this document. (6 pages)

_____	_____	_____
Client (Print name)	**Signature of Client**	**Date**
_____	_____	_____
Client #2 (Print name)	**Signature of Client #2**	**Date**
		_____
_____		
Signature of Parent or Guardian		**Date**
_____		_____
Counselor, George W. Rinker, MDiv., MS, LPC		**Date**