The Clarity Psychological Group
3915 Cascade Rd. SW Suite 250
Atlanta, GA 30331
P. (404) 699-3170 F. (404) 699-5680

Dear Client:

It is a pleasure to have you in our practice. We appreciate the opportunity to work with you. In order to avoid any discord or misconceptions in the future, this letter has been prepared for your information.

Informed Consent: Before obtaining any counseling care, it is important to gain sufficient knowledge regarding the types of treatment available, any risk, and potential benefits. This process of information gathering is known as receiving "informed consent". Although we will not make decisions for you, we will, however be available to assist you in making alterations and understanding their impact on you and others. We will always keep you informed of any changes in therapy that we may propose and any risks we foresee. In addition, we may suggest alternatives to therapy so that you can make well-informed decisions about your treatment.

INITIALS _____

Appointments/Payments: This office operates on an appointment basis. In order for your time to be reserved, it is essential that you make appointments in advance. Each appointment is a clinical hour, which is 50 minutes. If you need to cancel an appointment, please do so at least 24 hours in advance, so that you will not be charged for the session. **A $50.00 fee will be assessed for appointments cancelled within 24 hours of the scheduled visit.** If for any reason, you need to cancel your appointment, you are responsible for making contact with our office. You may leave a message with our answering service or voice mail, and you may also email us at *claritypsychgroup@gmail.com*. Although we may not receive the notification until the following business day, we will refer to the time-stamp. Documented efforts MUST be made in order for your cancellation fee to be waived.

INITIALS _____

A "No Show"/ missed appointment for a scheduled appointment will incur a $50.00 fee. This fee will be due and payable directly from the client and will not be billed to your insurance company. **As of January 12, 2015, Clarity Psychological Group clients are required to provide a credit/debit card to be held on file in our secure database to ensure a guarantee of payment in the event of "No-Show" or cancellation within 24 hours.** Until now, we have had trouble collecting fees, and as a result we have been forced to implement this change. You will be notified of the cancellation/no show fee at the time of the missed appointment, and of the charges applied to your account. You will also be notified via e-mail and sent a receipt for the transaction. This fee must be paid before any further counseling sessions will be allowed. *This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.*

As a courtesy, you may receive a call from our office confirming your appointment. The call may occur within 24-72 hours of your scheduled appointment. ***This is a courtesy of our office. If you do not receive a courtesy call reminder, you are still expected to arrive as scheduled for your appointment.***

INITIALS _____

Termination of Services: It is your right to terminate our relationship at any time. We would appreciate a one-week notice so that we might meet to discuss the termination and your future plans. At that time, we can assist you in locating another counselor and you may authorize the transfer of your records if necessary.

INITIALS _____

Confidentiality: With few exceptions, our conversations are confidential. State law, federal regulations and our Code of Ethics specifically guarantee this confidentiality. There are some situations however, in which confidentiality cannot be guaranteed. They fall within the following categories:

1. We must notify appropriate persons if we feel that a client may harm themselves or another individual. (This is our duty to warn.)
2. We must report the abuse, neglect, or exploitation of children or the elderly.
3. We are required to respond to a subpoena accompanied by a court order.
4. We conduct periodic peer reviews of client cases for best professional practices as well as for supervision purposes.

INITIALS _____

Emergency Procedures: We are committed to being responsive to your needs. However, there may be times when we are unavailable. If you need immediate help, you should call the emergency mental health number for your county, go to the mental health hospital nearest you, or go to your hospital emergency room**. For extreme emergencies, you should call 911.**

Billing and Insurance: The fee for counseling services may be up to $150.00 for each clinical hour. Self- pay clients are responsible for the session fee at the time services are rendered. If you have insurance coverage, we will be happy to assist you in filing claims on your behalf. Rates may change at any time; however we will do our best to notify you in advance of any changes.

When insurance is used, a co-payment or full payment of the session (depending on plan deductibles) may be required. Client payments are dictated by your insurance company. All client payments are due at the time of each session.

INITIALS _____

Disability/Personal Client Paperwork: All disability and other related forms received in this office from your insurance company, or otherwise received on your behalf to be completed by your therapist, **may incur a service fee up to $200.00 per occurrence. Any follow-up, second-tier, dispute, or additional set of forms may incur an additional fee up to $200.00.** All fees must be paid in advance by the client. Fees are not billable to an insurance company or Employee Assistance Program (EAP). **Forms may only be completed during a scheduled office visit.**

INITIALS _____

Telecommunication Informed Consent

In this electronic era, clients must be aware that there are risks to confidentiality and privacy whether clinical services are provided in-home, in-office, via phone, via VSee/Skype, etc.

Consultation, education, coaching and therapy may be delivered via e-mail, telephone or video conferencing. There are risks and benefits associated with communicating via electronic media. While we make every effort

to protect communications, it is important that you read this agreement carefully in order to provide informed consent for services.

This agreement outlines possible risks and benefits. By signing this form, I understand that the term "telecommunication" may include consultation, education, and treatment that may consist of the transfer of medical and or personal data about myself or my family members, e-mails, telephone conversations and education using interactive audio, video, or electronic communications.

I understand that telecommunication/coaching/consultation also may involve the communication of my medical/mental health information, both verbally and visually. I understand that I have the following rights with respect to telecommunication:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also may apply to telecommunication. As such, I understand that the information disclosed by me during the course of my therapy, coaching or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

(3) I understand that there are risks and consequences from telecommunication, including, but not limited to the possibility, despite reasonable efforts on the part of my consultant, that:
(a) The transmission of my information could be disrupted or distorted by technical failures;
(b) The transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

(4) Telecommunication services are billed at the same hourly rate as regular office visits.

If you have any questions about office procedures, therapy options, or other issues, please ask at any time. We look forward to working with you to assist you in "Bringing Clarity to confusion".

I have read the above letter and agree to abide by all the terms. I agree to enter into counseling with The Clarity Psychological Group. The benefits and risks of therapy and the duty to warn have been explained. I understand that it is my decision to continue therapy and that I may terminate at any time. I have been provided the opportunity to discuss any questions with my clinician and or staff, and my questions have been answered to my satisfaction.

_____ _____
Printed Name of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date

The Clarity Psychological Group
CREDIT/DEBIT CARD AUTHORIZATION FORM

It is a policy of this practice to keep a credit card on our secure database in case of a "no show" visit (late or no cancellation). Your credit card information will be protected along with the rest of your information. You may also choose to have this credit card charged with your regular session fees.

Patient's Name: _____
Cardholder's Name:_____
Credit Card Billing Address:_____
City, State and Zip Code: _____
Credit Card Type (Circle One): Visa Mastercard American Express Discover

Credit Card Number:_____
Expiration Date: _____/_____ CCVS/CVC2/CID: _____

I have read and agree to the office's policy of keeping my credit card information on file. This information may be used for payments of past due balances and/or no show visits. Regular fees will be charged with my verbal permission. I understand that this authorization will remain in force until termination of therapy, which MUST be done via a termination session, phone call, or in writing. I understand my card will be charged even if I terminate sessions after my scheduled appointment and that I must cancel my appointment 24 hours before my session to avoid the no show fee.

Authorized Signature: _____ Date: _____

Client Information

(Must be completed before services can be rendered)

Name: _____
First Middle Last

Address: _____
Street Apt City State Zip

Email: _____

Best contact number:_____ Alternate:_____

Sex: Male ☐ Female ☐ Date of Birth: _____

Marital Status_____

Employer _____

Employer Address _____

In case of emergency, notify: (Name) _____

Phone_____ (Relationship) _____

Primary Insurance / (Responsible Party's Information)

Name of Carrier_____

ID#_____

Name of Insured: _____ Insured's Date of Birth: _____

Social Security Number (Tricare only): _____ Phone: _____

(*We do not file with secondary insurance companies.)*

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of mental health benefits directly to The Clarity Psychological Group. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____Date_____