

The Barden Group, LLC

Client Information and Informed Consent

******(Please print single-side only and retain this page for your records.)******

About your therapist:

Rene Howey, MEd, LPC is a Licensed Professional Counselor in the state of Georgia as well as a certified Professional School Counselor. She completed her Masters of Education at Georgia State University in School Counseling and has 18 years experience working with children and adolescents in the private sector as well as the public school system. Currently, she is a middle school counselor for the Paulding County School District. Rene has a passion for helping adolescents and their families as they navigate life's challenges. She uses a variety of practical, solution focused strategies to help middle and high school students set goals, improve self-esteem and develop coping strategies. Rene believes in the "family concept" model integrating the family with the client as well as treating parents separately. Rene is a Cobb County native and is happily married with four children, one with special needs. She loves watching her kids compete in softball, basketball and lacrosse. Rene understands the difficulties and joys of raising children. She is ready to come along side you and your child to achieve stability and balance in your household.

About The Barden Group, LLC

The Barden Group, LLC a limited liability company in the state of Georgia providing a comprehensive therapeutic environment in which our therapists can provide counseling services for adolescents and adults. The Barden Group maintains professional offices for client therapy, as well as group services and peer consultation contracting with both fully licensed therapists and associate licensed therapists who all provide a full range of therapeutic services for adolescents, parents, families and individuals.

Potential Risks of Counseling

Your participation in counseling is of your own voluntary decision and may pose some risk to you. Therapy can produce a wide-range of positive and negative emotions which may make you uncomfortable or may impact your relationship with others. If you experience any difficulties during the course of your sessions, you should immediately discuss your concerns with your counselor.

In case of Emergencies

The Barden Group, LLC is NOT an emergency services provider. Therefore, we do NOT provide emergency services to potential or current clients. If you are experiencing a life threatening emergency please call 911. The following is a list of Non-EMERGENCY mental health resources that may be contacted for afterhours services:

Ridgeview Institute	770-434-4567
Peachford Hospital...	770-455-3200
Cobb Mental Health Crisis Line...	770-422-0202
Lakeview Behavioral Health...	678-713-2600

Client Information *(please add additional pages as needed)*

Client Name: _____ Date of Birth: _____

Parents/Guardians:(if child client) _____

Address: _____ City/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer/Occupation/School Info/Grade: _____

Emergency Contact (Name, Relationship, Phone): _____

Referred by: _____

What is the primary reason you are seeking counseling for you and/or your child/adolescent at this time?

When did you first notice the problem, issue, or symptoms?

What have you already tried to improve the problem or symptoms? What has helped or has not helped?

Have you or your child or family ever been in counseling before? If yes, please provide approximate dates and provider. What helped or did not help?

Please list current medications, dosage, prescribing physician and office telephone number, and length of time taking this medication.

Please list any allergies (food, pet, medication, etc.):

Please sign to indicate permission to consult with prescribing physician:

Have you or your child (if child client) ever expressed or experienced thoughts or feelings of suicide, self-harm, or harm to others? If yes, please provide approximate time frame(s) and details.

Please describe any significant medical history (including chronic conditions, hospitalizations, surgeries, premature birth, etc.)

What goals or changes would you like to see accomplished by you, your child and/or family through counseling?

Please list anything else you would like me to know before we begin our work together:

Timeline

To the best of your ability, please draw a timeline beginning with your birth noting any significant life events or changes. Examples include: Educational events, births, marriages, divorces, adoptions, relocations, deaths, losses, onset of current symptoms, hospitalizations, etc.

Family Tree

Please draw a family tree beginning with you and branching out to your parents, grandparents, children and grandchildren. Please include all spouses and non-biological family members

Confidentiality

Due to the sensitive nature of counseling, privacy and confidentiality will be of the utmost concern. Therefore, it is required that any and all information presented within the session(s), whether by the facilitator, therapist, counselor, or group leader (hereafter referred to as "counselor"); or client is not to be discussed outside of the therapeutic setting with anyone except for the following exceptions required by law: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, including suicidal and homicidal ideation 3) There is a reasonable suspicion of abuse/neglect against a minor, elderly person (60 years or older), or a dependent adult, 4) A court order is received directing the disclosure of information. Before mandated disclosure, privileged communication will be asserted on behalf of the client. Further, clients will be apprised of all mandated disclosures as soon as notification has been received. The Patriot Act of 2001 requires that in certain circumstances, I am required to provide federal law enforcement agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Confidentiality includes not acknowledging your receipt of services without your permission. Therefore, if you happen to see your counselor outside the office setting, please do not be insulted if your counselor does not initiate contact. This is for your protection; however, you may initiate an interaction based on your level of comfort and disclosure.

Additionally, some Counselors may be able to provide paperwork for you to file with your insurance company; however, insurance companies require a diagnosis for reimbursement. Confidentiality cannot be guaranteed by your therapist once information is given to insurance companies. Please check with your counselor for clarification.

My professional supervision and/or consultation with other licensed therapists are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality.

Yes, I understand my mail, voicemail, email, text messages, and all other forms of electronic communication(s) is a limit to confidentiality and privacy cannot be guaranteed. With acknowledgment of said notice, I authorize communication via the below methods:

Mailing Address:

Cell Phone: _____

Text Messaging: _____

Email: _____

Signature: _____

Date: _____

In the case of my death or major medical incapacitation, all my records will be accessed by Glen N Barden, LPC and, or, Melanie Peters, LPC.

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

In **working with couples and families**, the couple as an entity and the family as an entity is the client and the Counselor is not providing individual therapy for either half of the couple or for any one member of the family although session with individuals in the couple/family may be a part of the couples/family therapy. The Counselor **will not be a "secret keeper" nor will the Counselor facilitate secret keeping..** If anything significant is revealed in an individual session that the Counselor feels another party needs to be told, the Counselor will require it be brought up in the next session together so it may be therapeutically addressed. If the individual refuses to reveal the

Counselor recommended subject, the Counselor has the right to terminate the counseling relationship and refer the couple or family to another Counselor for treatment.

Divorce and Custody

*****I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.*****

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

1. THE BARDEN GROUP, LLC requires a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session BEFORE I am able to meet your child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and 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.

2. THE BARDEN GROUP, LLC Counselor(s) 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 I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

3. THE BARDEN GROUP, LLC requests all clients waive the right to subpoena THE BARDEN GROUP Counselors to court. This policy is set in order to preserve the efficacy and integrity of the therapeutic progress and relationship with you and/or your child(ren). A Counselors appearance in court often damages the therapeutic relationship between the client and Counselor, and it is the Counselors ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of their clients. By signing this agreement, you are waiving right to subpoena your Counselor and agreeing in fact to not have any clinical or personal records of the Counselor subpoenaed. THE BARDEN GROUP, LLC Counselors will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

4. In cases whereby a THE BARDEN GROUP, LLC Counselor is subpoenaed to appear in court even with this waiver – whether to testify or not – an upfront non-prorated charge of \$1,000 per day (i.e. the Counselors’ full daily rate) will be incurred. An additional charge of \$100/hr. (rounded up to 15 minute intervals) will be charged for Court Related work, including: any court- mandated appearances, document preparing, consultations with attorneys and/or the guardian ad litem, et al and travel time. All travel costs including airfare, \$0.55 per mile driving allowance, hotel expense (location acceptable to counselor), and \$50 per diem meal allowance will be incurred by the client.

I understand these policies and hereby waive any and all rights to subpoena Rene Howey, LPC and the clinical record on any current or future legal proceedings.

Printed Name _____ Signature _____ Date _____

Printed Name _____ Signature _____ Date _____

Scheduling and Cancellations

A minimum of 24 hours is required to cancel an appointment. If a client does not arrive for a scheduled appointment or cancels within 24 hours, a fee of the greater of the full session rate or \$75 will be billed. If there is a true, unavoidable emergency or serious or contagious illness, please call as soon as possible and I will work with you to reschedule and you may request waiver of the 24 hour policy.

Session parameters

Parenting sessions, individual counseling sessions and family sessions are 50 minutes. Sessions will start and end on time. To respect other appointments, if you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance

Counselor is not currently on insurance panels.

All fees are paid directly to The Barden Group, LLC. THE BARDEN GROUP, LLC accepts cash, checks, Master Card, Visa, and American Express.

There is a **\$25 fee for any returned checks**. That \$25 fee is due at the time of your next session, along with the payment for that session. If I receive two (2) returned checks from you, I will require that you pay using cash or credit card only from that point on.

Initial Intake Session: \$100.00

Individual Sessions: \$100.00

Family / Couples Sessions: \$125.00

Preparation Summaries of Treatment or Letter(s) of client requests (unless otherwise deemed court related correspondence): \$75 per item requested.

Court related fees: Counselors receive full standard session hour rate for court related matters.

Court appearance fees: Non-prorated \$1,000 per day, payable in advance, plus travel expenses.

A limited number of reduced fee slots are available with application and are extended based on financial need. Please ask about reduced fee options. I will be more than happy to discuss alternative payment agreements at our initial intake session. A reduced fee agreement will be signed once application is agreed upon.

Printed Name _____ **Signature** _____ **Date** _____

Printed Name _____ **Signature** _____ **Date** _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems. I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for services, or for other business activities, which are called in the law "healthcare operations". After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat you or your child. Of course, I will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

- 1) When there is a serious threat to you or your child’s health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
- 2) Some lawsuits and legal or court proceedings.
- 3) If a law enforcement official legally requires me to do so.
- 4) For workers compensation and similar benefit programs.

There are situations like these that do not happen very often. They are described in the long version of NPP.

Client Records

You should be aware that, pursuant to Health Information Portability and Accountability Act (HIPAA), I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of \$35 charged for copying and mailing the record for release.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number: Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists 237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

Signature indicating I have read and received the Notice of Privacy Policies:

_____ Signature

_____ Printed Name

_____ Date

Agreement to Enter into Counseling Services and Fee for Services Agreement

I have read or had read to me and understand all the information in the above paperwork. I have had a chance to review and ask questions and have all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling. I also hereby acknowledge that I have received the Notice of Privacy Policies.

Every time I schedule an appointment with my therapist I understand that I am entering into a contract with The Barden Group, LLC for the professional time and services provided for within that appointment time. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist’s professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agreed that my fee for sessions will be \$_____and I agree to pay this fee at the time of each session. I understand that THE BARDEN GROUP, LLC does not reimburse for cancelled appointments that were paid for in advance but that any such fees will be credited to your account and applied to future services provided.

I understand that The Barden Group, LLC’s cancellation policy requires 24 hours advanced notice in order to be released from the contract for my therapist’s time and services of preparation for my session.

I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged the greater of the full session rate or \$75 for the appointment. I also understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with my therapist directly and request a waiver of this policy.

I authorize _____ to schedule appointments on mine and their behalf.

I hereby authorize THE BARDEN GROUP, LLC to charge my Visa/ Master Card/ American Express (circle one)

Credit card number: _____

Exp. Date_____ **CVC Code:** _____ **Zip Code:** _____

Client (or parent/legal guardian of child client) Printed Name: _____

Client (or parent/legal guardian of child) Signature and date: _____

Therapist Signature and date: _____