Laura Graham, LPC, LLC
Informed Consent and Administrative Policies

Welcome. The following information is meant to inform you about my policies and my understanding of our professional relationship. Therapy is a relationship that requires open communication. If you have any questions about these or any other aspects of your psychotherapy, please feel free to bring them up at any time.

Professional Background and Philosophy:
I am a licensed professional counselor. I attended Georgia State University in Atlanta. I have been a therapist since 1996. I believe therapy is about making positive changes and understanding what holds us back from positive growth. I look forward to working with you and helping you make these positive changes. It is impossible to guarantee specific results regarding therapy. However, we will work together to achieve the best possible results for you. It is essential that you are actively involved in setting your goals.

Fee:
I do accept certain insurances. This will depend on if I am an in-network provider with that insurance panel. If you use your insurance, it will be important that we check to see if I am a provider and determine your mental health benefits. I try to do this prior to your first session. I will need a release of information to contact your insurance and to accept payment from your insurance company. **Please note that benefit verification is not a guarantee of payment by your insurance company. On rare occasions, insurance companies may deny payment therefore you will be responsible for payment.** However, I will do my best to work with you in regards to these situations.

My regular self-pay fee is $100 per fifty-minute psychotherapy session. My fees are the same for individuals, couples and families. I do not charge for brief phone calls, but do charge for longer calls (15 minutes or more.) Fees for these calls are due at the next appointment and are as follows: 15 minutes = $30.00, 20 minutes = $40.00, 30 minutes = $60.00. If you are late for your appointment, that amount of time is deducted from our session. Payment is due in full at the time of service, unless prior arrangements have been made. At the end of each session if needed, you will receive a receipt that you can submit to your insurance company for out of network reimbursement. There is a $30.00 return check fee.

Communication and Emergency Contact:
I do my best to return phone calls within 24 hours; however, occasionally there are unavoidable delays. Also, routine calls received after 5pm on Thursday and on the weekends will be returned the next business day. If you need to speak with me immediately, please indicate so on my voice mail and I will make every effort to call you back as soon as I possibly can. **In case of emergencies, dial 911. You may call Ridgeview Institute 770-434-4567 and ask for the access center. Children under 13 years old call Peachford Hospital 770-455-3200 and ask to speak to a counselor.**

Confidentiality & Exceptions:

Confidentiality is an essential part of the therapeutic process and is a commitment that I make to you. Consistent also with the mental health laws of Georgia, I will not release any information about you without your written consent. There are specific exceptions to the commitment of confidentiality:

- **When I consult with other mental health professionals about our therapy, such as supervision. Information that identifies you to others is not necessary in that instance.**
- **When I feel as though you are a threat to your own or someone else's safety.**
- **When a minor child or an incapacitated adult is endangered by abuse or neglect**

In each of these instances, I will make every effort to speak with you before I speak with anyone else. If you are seeing another healthcare provider or using your insurance, it may at times be necessary to exchange information regarding your treatment. In those cases, you will be asked to complete an authorization to release information.

Please review the Notice of Privacy Practices provided to you as part of this new client information. It describes in more detail your rights with regard to Protected Health Information. By signing this Administrative Policies sheet, you are acknowledging your receipt of the Notice of Privacy Practices.

Client Signature:

Your signature indicates that you have reviewed and understand this document, have had all questions answered to your satisfaction, and agree to adhere to the policies. A copy for your records has also been received.

_____ _____

Client Signature Date

(or signature of parent if client is a minor)

Cancelling Sessions /No Show Fees and Technology Statement

Cancellations:
If you cannot keep your appointment time, please contact me and give me at least **24 hours notice** so that I can make the time available for others. I do schedule you for a full hour session. If you cancel with less than 24 hours notice or you miss a scheduled appointment, you will be charged $60.00 for that appointment. Payment is due at time of the missed session. There are situations where giving less than 24 hour notice is understandable. We will discuss these situations on a case by case basis. If you are going to be more than 15 minutes late for your appointment, please let me know by calling **770-592-0566 EXT 3**. Please leave a message if you do not reach me directly. Otherwise, if you are more than 15 minutes late, I may assume you are not coming and may be unavailable. If this happens, you will still be charged for the missed appointment. Fees are not prorated if you are late.

*Please initial _____

Technology Statement:
Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please feel free to discuss this with me. However, please know that it is my policy to utilize text as means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. My email address is HIPPA compliant and you can email me but I ask that you leave therapeutic topics for sessions. You also need to know that I am required to keep a copy of all emails as part of your clinical record. Below please initial and confirm how you would like for me to contact you.

Email Address:

_____

*Please initial _____

Cell Phone:

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*Please initial _____