{Simplified} Life Solutions
Lauren M. Dack, LAMFT, LAPC
Informed Consent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and Lauren to work most effectively together, please carefully read the information below. If you have any questions, Lauren will be happy to discuss them with you.

Lauren Dack is a Master's level counselor who is a Licensed Associate Professional Counselor and Licensed Associate Marriage and Family Therapist approved by the Georgia Board of Professional Counselors, Social Workers and Marriage and Family Therapists. She is receiving supervision from Vickie George, a Licensed Professional Counselor and Marriage and Family Therapist and Direction from Emily Shupert, a Licensed Professional Counselor. Lauren has been working with men, women, couples, and families in the State of Georgia for over 4 years.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPAA applies to all heath care providers, including mental heath care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their heath care records. An explanation of those rights is attached to this document.

Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of:

1.) child abuse, elder abuse, or threats of physical harm to self or others,

2.) for clinical supervision purposes,

3.) if subpoenaed by a court of law,

4). If a guardian ad litem (GAL) is appointed in a custody case involving adolescent clients I have seen for counseling services and she/he is ordered by the court to have access to mental health practitioners and records therein, I am required to provide that information as it is court ordered.

5.) The Patriot Act of 2001 requires me in certain circumstances, to provide federal law 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.

6.) I am happy to provide paperwork for you to file with your insurance company; however, in doing so, there will be a diagnosis required with the paperwork and there may be a violation of your confidentiality, as insurance companies do not always observe the same strict confidentiality polices that I do as a Licensed Associate Professional Counselor. I am also willing to share information about our counseling sessions with any other professional or agency that you wish, provided you sign a Release-of-information form.

7.) In **working with adolescents,** though legally the parent(s) or legal guardian(s) of adolescent clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a adolescent's therapy, I honor what the adolescent 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.

8.) In **working with couples and families,** the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I ***will not be a "secret keeper" nor will I facilitate secret keeping.*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it or I may have to terminate the therapeutic relationship and refer you to another therapist.

Counseling Fees: The normal fee for a 50-55 minute session is $100 (includes time for handling administrative details such as scheduling the next appointment, etc). We ask that you keep your account current and pay by ***cash, check or credit card (make checks out to Simplified Life Solutions***) at the beginning of the session. We do not accept insurance, but are happy to provide you with a receipt at the end of the month if you wish to file your own insurance claim. If you are experiencing financial hardship, please speak to your counselor about this, so she can work with you. In the event of lack of payments received for over 2 sessions, no further sessions will be made until the balance is paid in full.

Cancellation of Appointments: If you must cancel your appointment for any reason, please call or email Lauren at 404.913.1102 or lauren@simplifiedatlanta.com at least **24 business hours in advance** of your scheduled appointment. If you miss your appointment, you will be billed at the full rate.

Late Appointments: Each appointment begins at the scheduled time and lasts for 50 minutes. If you should arrive late for an appointment, the appointment will begin shortly after your arrival and end at the normal time.

Telephone Calls/Emails: The purpose of email, telephone, or other electronic correspondence is to assist in our communication regarding scheduling, appointment information, homework assignments, and information regarding payment status. This type of communication is not a way to communicate therapeutic information regarding your counseling care and treatment as these matters are saved for your counseling session time. While I will take reasonable, precautions to protect your confidential information, as with any electronic communication, there is no way to completely secure communication. Should you need to contact Lauren, you may leave a message at 404.913.1102 Please leave your name, telephone number, and a brief message. Your call will be returned as soon as possible, usually within 24 business hours.

Public Contact: In the event that you see me outside of the counseling office, my policy is to not acknowledge you until or unless you respond first. If you would like to acknowledge me or not, I will not be offended as it is completely dependent upon your level of comfort and desire for discretion.

Please initial that you have read the above statements and agree with them: _____

Nature of Counseling: You have the right to choose alternatives and to participate in designing your treatment plan. The therapeutic relationship, which we establish, will be characterized by respect and cooperation. Through therapeutic techniques and methods, I will offer you ways in which you can reach your counseling goals and objectives. My services will be practiced in a professional manner that is consistent with the Georgia State Board of Examiners of Professional Counselors qualifications for ethical standards. You are entitled to an explanation of your condition and the treatment that will be provided as well as the probable duration and adverse risk involved. Please know that it is impossible to guarantee any specific results regarding your counseling goals for the counseling process, however, together we can work to achieve the best possible results for you.

Emergency Procedures: This practice is not staffed with a receptionist or paging system, therefore we are not equipped to handle emergency situations. In the case of an emergency, we recommend you contact either a hospital emergency room or the police depending on the situation. You can also call the Georgia Crisis Line at: *(800) 715-4225).*

Divorce/Custody Disputes: If you are ever become involved in a divorce or custody dispute, I am not able to provide evaluations or expert testimony in court. You should hire a different mental professional for evaluations or testimony that you may require. My position is based on two reasons: 1) my statements will be seen as biased in your favor because we have a therapeutic relationship and 2) the testimony might affect our therapeutic relationship and I must put this relationship first. By signing this informed consent document, you are acknowledging your full understanding of and agreement on my position concerning this matter.

I, _____, fully understand what I have just read and voluntarily request counseling services at {Simplified} Life Solutions and I agree to these terms and conditions.

_____ (signature of client) _____ (date)

_____ (signature of Parent or Guardian) _____ (date)

{Simplified} Life Solutions
Lauren M. Dack, LAMFT, LAPC
Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all heath care providers, including mental health care, and providers and health care agencies thought the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, {Simplified} Life Solutions is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

{Simplified} Life Solutions
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of {Simplified} Life Solutions Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and I may at any time, not or later, as any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy of the Patient Notification of Privacy Rights document.

_____ _____
Patient Signature Date

_____ _____
Parent Signature if patient is a minor Date

_____ _____
Guardian Signature if patient is legal charge Date

Consent to Correspond Electronically

While {Simplified} Life Solutions takes reasonable precautions to protect your confidential information, e-mail, texting & social networking is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a {Simplified} Life Solutions Staff member regarding my therapeutic care, the {Simplified} Life Solutions and/or his/her representative has my permission to correspond via that email address and other forms of electronic communications.

I give permission for a clinical staff member to email me regarding my therapeutic care at

_____@_____

The purpose of e-mail and other forms of electronic communication is to communicate with the client regarding scheduling appointments, reminding clients regarding their appointments, homework assignments, follow-up care according to staff or information regarding the clients' business account. Electronic communication is not a way of communicating new information regarding care or of communicating emergency treatment. You must call and talked to your individual therapist regarding any information towards your treatment at {Simplified} Life Solutions

In Case of Emergency:
If you are in an emergency situation and need to contact someone immediately to help you, you may call the following numbers:

Georgia Crisis Line: 1-800-715-4225
Atlanta Emergency Mental Health Services: 404-730-1600
Emergency Services: 911

___ I give {Simplified} Life Solutions my permission to add my e-mail address for the purpose of sending me notices of future events and other pertinent information through my e-mail.

{Simplified} Life Solutions

Payment Information

Payments are required at the date of services. You may pay through cash, check or credit cards. If you wish to pay by credit card, please complete the following:

Creditcard: MasterCard VISA

Number: _____

Expiration Month _____ Year _____

Address where bill is sent:

Street _____

City _____ State _____ Zip _____

Name as it appears on the card: _____

{Simplified} does not accept insurance as payment for services, although we will make every effort to provide the information necessary for you to file for reimbursement. You are responsible for payment at the time services are rendered.

By signing below you are indicating that you have read and agree to the above contract and that you also give authorization to {Simplified} to release any information necessary for you to secure insurance reimbursement for fees you have paid to restoration:

_____ _____

Client's Signature Date

_____ _____

Counselor's Signature Date

{Simplified} Life Solutions
Patient Notification of Privacy Rights

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION. (EFFECTIVE 4-14-03)

LEGAL DUTIES: State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

USE OF INFORMATION: Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

DUTY TO WARN AND PROTECT: When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

PUBLIC SAFETY: Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

ABUSE: If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES: Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH: In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

PROFESSIONAL MISCONDUCT: Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

JUDICIAL OR ADMINISTRATIVE PROCEEDINGS: Health care professionals are required to release records of clients when a court order has been placed.

MINORS/GUARDIANSHIP: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

OTHER PROVISIONS: When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

YOUR RIGHTS: You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1 per page, plus postage. You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing. Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

COMPLAINTS: If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Georgia Board of Counseling. If you file a complaint we will not retaliate in any way.

{Simplified} Life Solutions
Counseling Intake Form
Lauren M. Dack, LAMFT, LAPC

The following form, which will become a part of your confidential record, will enable me to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name:_____Date of Birth_____Age_____Sex_____

Present Address_____
Street

_____
City County State Zip Code

Home or Cell Phone: _____ Can we contact you at work? Work phone: _____

Email _____ Would you like to be added to our monthly email newsletter? Yes No

Ethnicity_____ Years of Education_____Referred by: _____

Marital Status: Single_____ Married_____(# of Years _____) Divorced_____ Separated_____

Presently Living With: Parents ____ Spouse ____ Roommate_____ Alone___ Other _____

Occupation_____Total Hours/Week_____

Employed by_____Phone_____

Religious Affiliation_____Church_____

Are you a member? Yes_____ No_____ Active_____ Inactive_____

Are you interested in having Christian principles incorporated into counseling? Yes No Maybe

Family member to notify in case of emergency: Name:_____

Address:_____ Phone:_____

Education: Circle last year completed:

GradeSchool- 1 2 3 4 5 6 7 8

HighSchool - 1 2 3 4

College - 1 2 3 4 5 6 + Other Training: _____

Family Members:

Relationship	Name	Age	Grade in School Last Completed	Occupation if Out of School
Spouse				
Father				
Mother				
Brother(s)				

Sister(s) _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Children _____ _____ _____ _____

_____ _____ _____ _____

Any miscarriages or abortions? _____

General Family History:

Approximately how many times did you family move when you were young? _____

Parents

If separated or divorced, how old were you at the time? _____

Father deceased? _____ How old were you at the time? _____

Step-father deceased? _____ How old were you at the time? _____

Mother deceased? _____ How old were you at the time? _____

Step-mother deceased? _____ How old were you at the time? _____

Father remarried when you were age _____ You lived with whom? _____

Mother remarried when you were age _____ You lived with whom? _____

Until age 18 tell how long you lived with Mother _____ Father _____ Step-mother _____ Step-father _____ Other _____

How did the step-parent relate to you? (kindly, poorly, affectionately, little discipline, etc.)

_____

_____Natural father's occupation

_____

Natural mother's occupation _____

Step father's occupation _____

Step mother's occupation _____

How many times was your father married? _____

Your mother? _____

Rate your parent's marriage: Miserable _____ Unhappy _____ Average _____ Happy _____ Very Happy _____ Their marriage lasted _____ years

Describe the relationship you have with your siblings:

Past:

Present:

Does your spouse wish to come for counseling? Yes___ No___ Maybe____

Have either of you ever filed for divorce?

Date of this marriage: Age when married: You___ Spouse____

Give a brief description of any previous marriages:_____

_____

Describe any physical problems you have that require medication or physical care: _____

_____

Are you currently receiving medical treatment? Yes _____ No _____

List any prescription and over the counter drugs/vitamins, herbs, taken in the last 90 days.

_____ dosage _____ # of times per day _____ prescribed by _____
_____ dosage _____ # of times per day _____ prescribed by _____
_____ dosage _____ # of times per day _____ prescribed by _____

List medical providers you have seen in the last 90 days _____
List any allergies _____
Primary Physician Name and phone#: _____ Do you have a psychiatrist? Yes No

Circle other drugs you have used in the past 90 days: Alcohol Caffeine Nicotine Marijuana
Cocaine Heroin Pain Pills Inhalants Amphetamines/Speed Ecstasy LSD Other

Previous Counseling/Therapy Yes_____ No_____ If yes, when?_____

With whom? Name _____Address:_____

_____

What experiences did you like the most and least about your last counseling experience? _____

_____

Have you ever been hospitalized for emotional of mental reasons, including substance abuse rehab? _____yes _____ no
Year _____ Reason _____
Year_____Reason _____

Is there a history of alcohol or drug use in your family? _____

Has a friend, family member or relative discussed concerns about your use? _____

Have you ever been concerned about your drinking or other drug use? _____

Briefly describe the problem that prompted you to seek counseling at this time: _____

_____

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped?

_____

_____

_____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

_____

_____

What have you already done about the problem? _____

What are your goals in coming to counseling? _____

Are there other people who play a major role in causing your problems or in helping you cope with your problems?

Yes ____ No _____ Explain briefly _____

_____

Is there anything else that you believe might be important for your counselor to know at this time? _____

_____

_____

_____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern						Moderate Concern				Extreme Concern

_____ Anger/Temper

_____ Depression

_____ Education

_____ Eating difficulties

_____ Fearfulness

_____ Nervousness

_____ Financial problems

_____ Marital problems

_____ Physical problems/Headache

_____ Pornography

_____ Problems with social relationships

_____ Problems with children

_____ Religious/Spiritual Concern

_____ Sexual Concerns

_____ Thoughts of suicide

_____ Trouble making decisions

_____ Unhappy most of the time

_____ Use of alcohol

_____ Use of alcohol by family member

_____ Use of other drugs

_____ Work

_____Worry

_____ Other (specify) _____

I have read the Counseling Informed Consent and voluntarily request counseling services at **{Simplified} Life Solutions** in accord with terms described on the Informed Consent document.

Signature _____ Date _____

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Parent/Guardian _____ Date _____

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION

Please Complete the Following Sentences (For Adults):

1.) The most important thing to me is

2.) I worry about

3.) What I do best is

4.)I have sometimes felt guilty about

5.) What makes me angry is

6.) My biggest mistakes were

7.) My job

8.) What makes me nervous is

9.) My personality would be better if

10.) I often felt that mother

11.) Jesus Christ is

12.) My temper

13.) My childhood

14.) Prayer is

15.) My biggest disappointment

16.) To me, sex is

17.) I would be better liked if

18.) I often felt that father

19.) God to me is

20.) My children (child) (brothers and sisters)

21.) Women are

22.) What hurts me most is

23.) My biggest problem in life is

24.) Men are