***Johanna Wendell, LLC***

***Johanna Wendell, MA, LPC***

***1820 The Exchange #550***

***Atlanta, GA 30339***

***404-981-3235***

**Information for Clients and Informed Consent**

# About your therapist

I am a Licensed Professional Counselor in the state of Georgia. I have a Master's degree in Clinical Psychology from Georgia State University with rich experience providing psychotherapy services for adolescents and adults.

# Benefits and Risks of Counseling

The benefits of counseling have been shown in many well-researched studies. However, change and the processes involved in creating positive change can at times be difficult and unsettling. In some cases, symptoms worsen before improving. Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed.

# After Hour Support and Emergencies

I do not provide emergency services. If you have a life threatening or mental health emergency please call 911. After you call 911 you may call me during business hours at 404-981-3235 and leave me a confidential voicemail. I will call you back when I have finished all sessions or between sessions if possible.

## Other after hour Mental Health Resources (not to be substituted for calling 911 with emergency):

### Ridgeview Institute at 770-434-4567

1. Peachford Hospital at 770-455-3200
2. Cobb Mental Health Crisis Line at 770-422-0202

4. Lakeview Behavioral Health at 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?

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

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

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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?

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

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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.

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

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

# Confidentiality

It is a client’s legal right that our sessions and my records about you are kept private. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are exceptions as follows:

1. When the client signs a release of information requesting that the therapist divulge information.
2. When a client is believed to be a danger to self or others.
3. When a minor is suspected of experiencing physical or sexual abuse, neglect or is deemed to be in danger, your therapist is legally and ethically bound to make a report to the Department of Family and Children’s Services.
4. When disclosure is required by a valid court order.

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.

Additionally, I am happy 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.

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.

If you should choose to communicate with me via email, confidentiality cannot be guaranteed and information may be accessible to others. Please indicate if you consent to us corresponding via email by signing here:

### **Yes,** I understand my email is a limit to confidentiality and I do authorize you to communicate with me via email: (Please provide the email address where you authorize me to send you email):

### (Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Email address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

More on Confidentiality:

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 my client and I am 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. 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.

Telemental Health

I offer phone and video sessions for your convenience. These communications can never be 100% ensured for confidentiality. Also, there could be potential limitations of these means of services (e.g., faulty internet connection, dropped calls, etc). I also correspond via email and text messages. While I am happy to schedule appts via text message and answer text messages, I cannot guarantee when I will get back to you. I always try my best to get back to clients within 1 to 2 business days, but I cannot commit to responses outside of business hours. I still encourage you to reach out, put please be aware that I may not be able to return your message in any given timeframe if it is due to anything other than scheduling or rescheduling appts. If you are in need of immediate help, please call 911 or a crisis hotline for immediate assistance. Similar with phone and video sessions, it is impossible to ensure that these means of communication are 100% confidential, so signing this indicates you are aware of the risks of communicating via telemental health services and consent to engage in this communication given the known risks.

# Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Divorce and Custody

***\*\*I am not a custody evaluator and can not make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluations 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. I require 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. I 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. I ask all my clients waive the right to subpoena me to court**.** This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child(ren). My appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement, you are waiving right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if you would prefer.
4. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of $250/hour of my professional time. Any of my time dedicated to any court- mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $250 per hour.

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

**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 inside of 24 hours, there will be a charge billed equivalent to the cost of your session (e.g., $190, or $100 if you have a reduced fee). 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 45 minutes. Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time. I also offer other lengths of sessions so feel free to inquire about shorter or longer sessions based on your particular needs (eg ½ session or ~23 minutes, 60 min sessions, 75 min sessions etc).

Fees, Payment, Insurance

I am not currently on insurance panels. I will be happy to provide paperwork for you to file with your insurance company for out of network reimbursement.

A limited number of reduced fee slots are available with application and are extended based on financial need. Please ask me 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. Occasionally, I will check in with you to see whether you are able to pay an increased fee such as if your circumstances have changed or I have increased my rate.

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: $190

All other Sessions: $190

Preparation of Summaries of Treatment or Letter at the request of the client: $75-$190 depending upon length, per item requested

Court related: $350/hour of any and all time spent on the case

Screenings and checklists at the request of the client: $75

**Client Records**

You should be aware that, pursuant to 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 $50 charged for copying and mailing the record for release.

**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 Johanna Wendell, LPC and for the professional time and services provided for 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, 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 Johanna Wendell, LPC 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 Johanna Wendell, LPC’s cancellation policy requires 24 hours advance 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 cost of the appointment. I hereby authorize Johanna Wendell, LPC to charge my credit card if indeed I fail to observe this cancellation policy**. 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 use a credit card processing system called Ivy. It will send you a text message, which will ask you to enter your name and credit card information. It stores your information in a password protected, HIPPA compliant site that keeps your credit card information blind, even to me. If you would like for me to charge your credit card, I can do so, and it will send you a text message receipt.

Client (or parent/legal guardian of child client) Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client (or parent/legal guardian of child) Signature and date\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature and date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_