

Orion Crook, MA, LPC

OrionPsychotherapy@gmail.com
 OrionPsychotherapy.org
 404.500.6102

**Licensed Professional Counselor**

1450 Ralph David Abernathy
 Blvd SW, Suite 308
 Atlanta, GA 30310

Informed Consent Form**Welcome**

This statement is designed to provide you with an overview of the professional relationship that we will establish. Provision of the following information and written acknowledgement of its receipt are required by Georgia state law. I welcome the opportunity to discuss any questions or concerns you may have regarding this agreement or my services.

Counselors practicing counseling for a fee must be licensed with the Georgia Composite Board of Professional Counselors, Social Workers & Marriage and Family Therapists for the protection of the public health and safety. Licensure of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

My Training and Approach to Therapy

My educational foundation is a Master of Arts degree in psychology from the University of West Georgia. My training covers a wide range of theory and techniques, with emphasis on the **Humanistic** approach to therapy and living. Some particulars that stood out in my studies are Gestalt, Existential and Experiential approaches in the therapeutic relationship. In my opinion, these all take a focus on what is present in the room and the experience of expression. I find that expression in all of its form is an access point that can help us explore who you are and what you are trying to create in life.

Some people come to therapy to deal with an immediate problem. Then they go on with their lives. Others want to explore deep issues of spiritual and emotional growth. In the therapy process we talk about life in a way that is different from every-day conversations. We connect with meanings underneath the circumstances and begin to notice patterns. The therapy process creates a container for awareness, and hopefully a safe space to let something new happen. I invite you to be an **active participant** in helping me to understand you and your concerns, as well as letting me know if there is anything occurring in the session that causes you distress. **Please feel free to repeat things, and let me know when I am not getting something you said.**

What we explore is often up to you, and I may provide feedback, support, or probing questions. Sometimes I find myself feeling like everything has meaning, and above all the way you feel in the world or the world makes you feel is real and important in our work. I utilize a person-centered approach, which means that our sessions will start with you and your needs. Together, we will explore what brought you to therapy and see where the conversation takes us. At first I will spend most my time listening deeply and reflecting what I hear. As we move on I may point out what I see, how I see you moving throughout the world, and begin to support you by providing some awareness. This component of our work together is directed at providing you with the tools and insights that will help you with your concerns and goals. As we continue I may ask that you take certain focuses between sessions, journaling, experimenting with your experiences or practicing a technique; in some ways I may assign "homework." This opportunity to explore and examine your experiences can lead to a clarity that enhances your insight and ability to make healthy and necessary changes in your life. In this way, you learn to access, trust and use your own internal resources for well-being and health. You also learn to identify and reach for helpful resources and persons outside yourself.

An area of our work that might be different than what you would experience with some other therapists is an **expressive therapy approach**. We will discuss the things in your life that help you to express yourself, and we may even engage in them during the session. Art, music, fashion, movies, books, dancing, journaling are just the beginning of a list of activities that we may explore with therapeutic intent inside and outside of the office setting. Bringing the experiences that help you to express yourself into therapy will provide a dynamic way for you to unfold and for me to engage with you. I find that these may be a powerful tool in the realm of self-care and my hope is that I can deepen your relationship with something that is already rewarding and often therapeutic for you.

As with any intervention however, there are also risks associated with counseling. First of all, **therapy is not an instant or even guaranteed cure. Secondly, risks can include experiencing uncomfortable levels of feelings like sadness, anger and anxiety.** Some changes can lead to what seem to be worsening circumstances or even losses. Throughout your therapy, I will be working closely with colleagues to ensure that I am providing you with the best possible course of treatment. Moreover, the risks

and challenges of therapy often lead to benefits. I will be working to support you through the challenges of change and look forward to helping you move toward the benefits and goals you seek in counseling. I appreciate your courage in considering counseling and taking a step in an intentional direction.

I do not work with clients whom, in my professional opinion, I cannot help using the resources and techniques I have available. If that is the case, I will give you some referrals that will be a better fit for you.

Supervision

My supervisor is Annie Kelahan who can be reached at 404.564.5132 or Annie.kelahan@gmail.com. As mentioned below I will consult (talk) with my supervisor about your treatment as well as additional supervision I might have. During these consultations, neither your last name nor other unique identifying information will be used. These other persons are also required by professional ethics to keep your information confidential. In the case of my death or major medical incapacitation, all of my records will be accessed by Annie Kelahan, LPC.

What You Should Know about Confidentiality in Therapy

I will treat what you tell me delicately. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about – in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a “secret” that I cannot keep secret. We can discuss any questions you might have.

1. **When you or other persons are in physical danger**, the law requires me to tell others about it. Specifically:

- i. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
- ii. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
- iii. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
- iv. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding**, you can prevent me from testifying in court about what you have told me. This is called “privilege,” and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify.

3. There are a few other things you must know about confidentiality and your treatment:

1. I may sometimes consult (talk) with another professional about your treatment. During these consultations, neither your last name nor other unique identifying information will be used. This other person is also required by professional ethics to keep your information confidential.
2. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.
3. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to

review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

4. Finally, here are a few other points:

a. To increase the effectiveness of my work, I at times may have a colleague join me as a co-therapist for one or more of our sessions. **I will seek in advance your specific permission to have a co-therapist join us.** I may also record a session to play for my supervisor. Again, I will seek in advance your specific permission to record a session.

b. If you want me to send information about our therapy to someone else, you must sign a **“consent to release information”** form. I have copies which you can see so you will know what is involved.

i. If you have been referred directly to me by someone else, I may, as a good business practice, acknowledge to them that you have contacted me and thank them for the referral. I will not discuss your situation with them unless I have your written permission.

c. Confidentiality also extends to situations where I may **see you in a public place** (restaurant, store, business event, office building, etc.). I am required to keep your identity as my client private. I will not address you in public unless you speak to me first and if you approach me to talk I will not disclose where I know you from. If I am with other people, I will not introduce you to them to further protect your privacy as a client. Similarly, **I will decline invitations to connect on social networking websites. Please know that it is possible we may have outside of the office engagements due to the small nature of minority communities, and that if we run into each other we will process it the following session.**

d. Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court. If you should choose to communicate with me via email, confidentiality cannot be guaranteed and information may be accessible to others.

Confidentiality in Telemental Health (email, texting, and video sessions)

Video Sessions

You may at some point in your sessions have a video session due to moving or being on vacation. Please know that although I use a secure video chat platform, that I can not confirm complete confidentiality of the platform. I have met all Georgia Board standards in order to be able to provide Telemental Health.

Email and Text Risk

The transmission of client information by email and/or texting has a number of risks, which include, but are not limited to, the following:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that confidentiality of such communications could be breached by a third party.

Email and Text Conditions

I cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. I am not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Clients must acknowledge and consent to the following conditions:

- Email and texting is not appropriate for urgent or emergency situations. I cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- The client should call and/or schedule an appointment to discuss complex and/or sensitive situations rather than send email and/or texts regarding such situations.
- I will not forward client's identifiable emails and/or texts to outside parties without the client's written consent, except as authorized by law.
- Clients should use their best judgment when considering the use of email or texts for communication of sensitive medical information. I will not be responsible for the content of messages.
- I am not liable for breaches of confidentiality caused by the client or any third party.

Client Acknowledgement and Agreement

By signing below, I acknowledge that I have read and fully understand this noted above. I understand the risks associated with

the communication through Telemental devices between Orion Crook, LPC, and I, and consent to the conditions and instructions outlined, as well as any other instructions that the Therapist may impose to communicate with me by email.

Please let me know which email is most secure to contact you at here:

Client: _____ **Parent:** _____

e. In **working with children (or adolescents under 18)**, legally the parent(s) or legal guardian(s) of the child 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, plans and progress as well as recommendations. Of course, the exceptions above about dangerousness to self or others apply here also.

Appointments and Fees

Appointments are usually scheduled once or twice a week. Individual sessions last for 50 minutes. When I see couples or families the session will often be 2 hours long. One session hour lasts 50 minutes, so a 2- hour session would last for 100 minutes. **It is expected that your sessions will begin and end on time. If you are unable to attend a scheduled session, please call to cancel or reschedule at least 24 hours in advance of your appointment to avoid being charged for the visit. If you miss a session I have the right to bill your credit card directly, I will try to let you know but can not guarantee this will happen. It is very important for you to know if you are using insurance and miss a session without 24 notice you will be required to pay the full contracted rate out of your pocket.** 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.

My standard fee is \$150 per 50 minute session, although it may be adjusted on a sliding scale, if requested. The sliding scale is dependent upon gross household income and family size. The fee you will be charged is discussed and set during our first session. **It may be renegotiated later in treatment depending on changes in your financial status.** Changes in fees will be made only after a discussion with you has taken place at least one session before the change is to be implemented. This fee is standard regardless of the number of people attending the session. I do not often do phone sessions, but can if it is determined to be beneficial for you. I would ask that this is kept to a minimum and that we discuss this before we agree to a phone session.

Payment must be made at the beginning of each session unless we specifically agree on another payment schedule. **I accept checks (paid to Orion Psychotherapy or Orion Crook), cash, Visa, MasterCard, American Express or Discover. Due to credit card fees I will charge an extra \$3 to cover the 3.25 fee I am charged.** A \$30.00 fee per check will be charged for returned checks. A finance charge of 1.5% per month or \$2.00 minimum, whichever is greater, will be assessed on balances outstanding over 30 days, unless we have made other arrangements in advance of you incurring a debt to me. In any case where a bill is accumulated, we will have a written agreement regarding a payment schedule.

I cannot take Medicaid, Medicare, Peachcare. I will offer a supporting documentation if your insurance covers "out of network" therapeutic services coverage and tend to ask for a 10 dollar increase per session to cover the extra time. However, insurance companies often require a diagnosis for reimbursement. Confidentiality cannot be guaranteed by your therapist once information is given to insurance companies.

If I am doing work related to your treatment that is outside the bounds of our scheduled counseling, **you will be billed on an hourly basis for all the time I spend on your case.** This includes travel time to another location (such as the hospital, your home, an attorney's office, or another setting), meeting with other professionals regarding your case, writing reports, preparation time, etc. My hourly fee for this type of work is the same as the fee you are charged for your therapy session.

My number is 404.500.6102. I check my voicemail at regular intervals throughout the day. If there is an emergency, and you are unable to reach me and are not responded to by one of my colleagues, and remain in urgent need of help, call **Fulton County Crisis at 404.730.1600, Dekalb County Crisis at 404.892.4646,** or call **911.** If you are outside of this area, you may need to contact another local area crisis line or call 911 for immediate help.

You always have the right to request a change in treatment or to refuse therapy. It is important that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through this difficulty together. If we are unable to do so, I will assist you in finding another therapist. **Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session.** I consider it of therapeutic value to you that the counseling relationship be closed in a straightforward manner, ensuring that all counseling issues have been dealt with to the best of your and my abilities. I also request this to demonstrate the importance of establishing boundaries and closure for all parties, and to intentionally set aside the therapeutic relationship as a behavior different from those we habitually engage in. In any case, notice of termination will result in my scheduling other clients into your regularly scheduled time slot. If you cancel an appointment or miss an appointment without leaving notice of rescheduling with my

voicemail, notice of termination will be assumed and your time slot will be given to the next available client. As well, you will owe to cost of the missed session. **Please know that all the art work left with Orion Psychotherapy will be the property of the organization and able to be sold, used, and shown by Orion Psychotherapy.**

For those who are being billed through insurance

I authorize the release of any medical or other related information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments.

I authorize payment of medical benefits to the undersigned physician or suppliers for service described below (in the Health Insurance Claim Form).

Quality of Service

If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel that this does not resolve the issue, you may contact one or all of the following:

Georgia State Dept of Licensing 237 Coliseum Drive Macon, GA 31217 478.207.1670

Committee on Ethics and Professional Practices 1717 "K" Street, N.W., Suite 407 Washington, DC 20006
202.429.1825

Please bear in mind that I am not able to give you legal advice. The signatures here show that we have each read, discussed, understand and agree to abide by the points presented above.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. **Permissible Uses and Disclosures Without Written Authorization** I may use and disclose Protected Health Information without written authorization, excluding Psychotherapy Notes, for certain purposes as described below.

1. **Treatment:** I may use and disclose PHI in order to provide treatment to clients.
2. **Payment:** I may use or disclose PHI so that services are appropriately billed to, and payment is collected from, health plans.
3. **Health Care Operations:** I may use and disclose PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.
4. **Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that a client is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to the health or safety of a client or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.
5. **Records of Disclosure:** Records of disclosure of PHI without client authorization will be maintained in the case record as required by HIPAA standards. Records of disclosure will include:
 - A description of the information to be disclosed;
 - Who (individual or organization) is making the request;
 - Expiration date of the request;
 - A statement that the individual has the right to revoke the request;
 - A statement that information may be subject to re-disclosure by the receiving party;
 - Signature of the client or their representative and date;
 - If signed by a representative, a description of their authority to make the disclosure. Records of disclosure will be maintained for at least six years.

Uses and Disclosures Requiring Written Authorization

B. **Psychotherapy Notes:** Notes documenting the contents of a counseling session (“Psychotherapy Notes”) will not be used or disclosed without written client authorization.

C. **Marketing Communications:** I will not use health information for marketing communications without written authorization.

D. **Other Uses and Disclosures:** Uses and disclosures other than those described in Section A above will only be made with written client authorization. Clients may revoke such authorizations at any time.

My signature below indicates that I have received a copy of this information.

Client Name

Signature & Date

Therapist Name

Signature & Date