Alexander Kohl, Ph.D., LPC, CCH, DCC

North Metro Psychological Services

540 Powder Springs Street, Suite E-31

Marietta, GA 30064

Information for Clients and Informed Consent

I am a licensed professional counselor in the state of Georgia. I have a Master of Science in Behavioral and Neural Sciences and a Ph.D. in Clinical Psychology. I have rich experience providing psychotherapy services for adolescents and adults.

I provide services through North Metro Psychological Services, LLC; however, all billing and insurance inquiries are filed under Neurotherapy Associates, LLC. Neurotherapy Associates, LLC, is a limited liability company in the state of Georgia that is owned and operated by Dr. Alex Kohl.

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, especially with children, 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:

Neurotherapy Associates, LLC is not an emergency services agency. 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 470-217-7347 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):

1. **Ridgeview Institute at 770-434-4567**
2. **Peachford Hospital at 770-455-3200**
3. **Cobb Mental Health Crisis Line at 770-422-0202**
4. **Lakeview Behavioral Health 678-713-2600**

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, 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, phone, video,or text message, confidentiality cannot be guaranteed and information may be accessible to others.

***These forms of communication should only be used for administrative purposes (e.g., scheduling and rescheduling). By checking next to each of these modalities below, the client acknowledges that these forms of communication are NOT encrypted and may be compromised due to hacking from a third party.

Yes, I understand email, phone, and text messages are a limit to confidentiality and I do authorize you to communicate with me via:

___email ____phone ____text message:

_____
(Signature)

Telemental health sessions (video) may also be conducted through Doxy.me, which is a HIPAA compliant online platform for sessions. All video sessions will be billed at the regular sessions rate.

Please provide the email address/phone number where you authorize me to contact you:

_____

In the case of my death or major medical incapacitation, all of my records will be accessed by Lisa Korey, Psy.D. and/or Lisa Banegas, LMFT

More on confidentiality:

In general, Georgia law provides that the age of majority is 18 years, and every person under 18 is a minor, according to O.C.G.A. Section 19-7-2. According to this Statute, minors are not competent to consent to treatment by a mental health professional, and that parents must consent to treatment for their minor children who are under the age of 18.

There are, however, several basic exceptions to this general rule. Those exceptions are as follows:

1. Minor parents: minors who are parents may consent to treatment for their children;
2. Drug abuse: minors may consent to treatment for drug abuse;
3. Emancipated minors: An emancipated minor is one who is living independently and supporting him/herself, and living independent of a parent;
4. Reproductive issues: Under Georgia law, any female may give consent for treatment, regardless of her age, for treatment related to pregnancy, birth control, or child birth; and
6. Venereal disease: A minor in the State of Georgia who has contracted an STD may give consent to treatment for the condition, regardless of age.

Social Media Policy

Individual therapists at North Metro Psychological Services do not connect with clients on social media sites. This is to protect your confidentiality and the integrity of the therapist/client relationship.

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. 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 the right to have me subpoenaed and agreeing 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 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 $150/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 $150 per hour.

I understand these policies and hereby waive any and all rights to subpoena Alex Kohl, PhD, 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 inside of 24 hours, the session will be billed at the usual rate. 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. If you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance

If I am not a provider for your insurance, I will be happy to provide paperwork for you to file with your insurance company for out of network reimbursement. I cannot guarantee your insurance company will reimburse for my services.

All fees are paid directly to Neurotherapy Associates. We do accept Master Card, Visa, Discover, and Amex, as well as HSA and HRA insurance cards.

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.

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: $150

All other Sessions: $150

Preparation of Summaries of Treatment or Letter: $75 per item requested

Court related: $150/hour of any and all time spent on the case

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 to do this 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). Please refer to the NPP for more information. 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." If you do not consent and sign this consent, 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 who 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 worker's compensation and similar benefit programs.

There are some other 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 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.

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:

_____ _____ _____

Printed Name Signature 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 Neurotherapy Associates 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, 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 Neurotherapy Associates 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 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 usual rate 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.

Information to be kept on record:

Clients name:_____ DOB:_____

Address:_____

_____

Name on Credit Card:_____

Credit Card Number:_____

Exp. Date:_____ CVV:_____

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

Therapist Signature and date:_____