Jo-Anne Liakakos, MA, LPC, NCC
Major Counseling Solutions & Consulting
11815 Northfall Lane, Suite 1006 Alpharetta, GA 30009 770-674-4422

Informed Consent

Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about the client cannot be shared with another party without the written consent of the client or the client's legal guardian; except where disclosure is required by law. Some noted exceptions are as follows: suicidal/homicidal intent or plan, abuse of children and vulnerable adults, prenatal exposure to controlled substances, legal action to respond to a subpoena from court.

Litigation Limitation/Court

Due to the fact that the therapeutic process often involves disclosure of many matters which may be confidential in nature, it is agreed that should there be any legal proceedings neither you (client or parent/guardian of client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Cancellation

Since scheduling an appointment involves the reservation of time specifically for you this time cannot be used for another client, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. A full session fee is charged for missed appointments or no show cancellations with less than the 24 hour notice. The full fee will be added to the next session, if a credit card is unavailable. If the client(s) do not show up for the next session a bill will be mailed directly to the client(s). Unless another agreement is reached the full fee will be charged for sessions missed without such notification.

Termination

During the initial intake process and the first few sessions I assess if I can be of benefit to you. I do not accept to work with clients that I feel are outside of my area of expertise. In such a case I will provide you with a number of referrals that you may contact. If at any point during therapeutic services I assess that I am not effective in assisting you with reaching your goals I will discuss this with you and provide you with a number of referrals that may be of assistance. You have the right to terminate therapeutic services at any time. If you do so I will offer to provide you with names of other professionals that may provide services you may prefer.

Billing/Financial Responsibility

Fees for service are due at the beginning of each session. A **$50 returned check fee** will be charged to my account should the bank return a check. Additionally, clinical counseling services

could be terminated due to insufficient payment. We reserve the right to terminate services to any client's that have an outstanding balance. In the event that we are unable to collect on your account, be advised that uncollected fees may be turned over to the offices collection agency. Only necessary information will be released to them but please be assured that we will make every effort to work with you prior to allowing this to happen.

Emergency Procedures
If you have an emergency that I need to be alerted of between sessions please call 770-674-4422. Your call will be returned as soon as possible as messages are checked daily during normal business hours. If an emergency situation arises that needs immediate assistance and you cannot wait for a call back please call 911 or go to your nearest hospital emergency room. If a life threatening crisis occurs you agree to contact 911 or go to a hospital emergency room.

CONSENT TO TREATMENT: By signing this Informed Consent as the client or Guardian of said client, I acknowledge that I have read, understood, and agreed to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that was unclear to me. I am voluntarily agreeing to receiving a mental health assessment, treatment, and services for myself or minor child, and understand that I can terminate such treatment or services at any time. My signature below indicates that I understand this informed consent and the HIPPA Notice of Privacy Practices.

_____

Client/Parent/Guardian Signature Date

_____

Therapist Date