MICHAEL FREEMAN, Ph.D., LPC, C.Ht.

11720 Amber Park Drive, Suite 160, Alpharetta, GA 30009

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to Michael Freeman, Ph.D. We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at Michael Freeman, Ph.D.. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Theoretical Views & Client Participation

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only need a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist at any point.

In order for therapy to be most successful, it is important for you to take an active role, both during and between sessions. This also means avoiding any mind-altering substances including but not limited to alcohol and non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree you are capable of facing life's challenges in the future without the therapist(s) here at Michael Freeman, Ph.D. We also do not believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored behind two separate locks. Additionally, your therapist will always keep everything you say completely confidential, with the following exceptions: 1) you direct your therapist to tell someone else and you sign a "Release of Information" form; 2) your therapist determines that you are a danger to yourself or to others; 3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or 4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him/her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal

right. If for some reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Structure and Cost of Sessions

Your therapist agrees to provide psychotherapy for the fee of $150 per 50 minute session and $175 per 75 minute session. Needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. The fee for each session will be due at the conclusion of the session. Credit or debit cards are acceptable for payment, and we will provide you with a receipt of payment.

We are in network with specific insurance companies, but are slowly transitioning to a self-pay model. Once we make that transition, we will be glad to provide you with a superbill to file with your insurance company if you wish to file for reimbursement out of network.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

In Case of an Emergency

Michael Freeman, Ph.D. is considered to be an outpatient private practice, and we are set up to accommodate individuals who are reasonably safe and resourceful. We are not available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he can discuss additional resources or transfer your case to a therapist or clinic with 24 hour availability. Generally, your therapist will return phone calls within 48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call the Georgia Crisis and Access Line (GCAL) at 800-715-4225
- Call the National Suicide Prevention Lifeline at 988
- Call 911
- Go to your nearest emergency room

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other way (e.g., social, business, etc.), you would then have a "dual relationship." Dual relationships may compromise your treatment and, therefore, are discouraged in the mental health profession. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us to maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for us not to use a cell phone when contacting you, please let us know.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with your therapist. However, please know that it is our policy to utilize these means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy of all emails and texts as part of your clinical record.

Facebook, LinkedIn, Etc: It is our policy not to accept requests from any current or former client on social networking sites such as Facebook or LinkedIn because it may compromise your confidentiality.

Google, etc.: It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: We may post psychology news on Twitter or write an entry on a blog. If you have an interest in following either of these, please let your therapist know so that he/she may discuss any potential implications to your therapeutic relationship. Once again, maintaining your

confidentiality is a priority. We would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to our content.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

Statement Regarding Ethics, Client Welfare & Safety

Michael Freeman, Ph.D., assures you that our services will be rendered in a professional manner consistent with the ethical standards of the Georgia Composite Board of Licensed Professional Counselors, Social Workers, and Marriage and Family Therapists.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

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We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form provided to you separately. Your signature also indicates that you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Michael Freeman, Ph.D., LPC, C.Ht.
Licensed Professional Counselor
11720 Amber Park Dr., Suite 160, Alpharetta, GA 30009
Tel. (404) 660-7955

Client Information Form

Today's date: _____

Your name: _____

Last First Middle Initial

Date of birth:_____ **Social Security #:**_____

Home street address: _____

City:_____ **State:**_____**ZIP:**_____

Name of Employer:_____

Address of Employer:_____

City:_____**State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____**Email:**_____

Referred by:_____

- May I have your permission to thank this person for the referral?
  Yes No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Persons to notify in case of any emergency:_____

Name **Phone**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature):_____

Please briefly describe your presenting concern(s)/goals for therapy:_____

_____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____
Do you consume caffeine? YES NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____
Do you use any non-prescription drugs? YES NO
If YES, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? YES NO
Have you ever been in trouble or in risky situations because of your substance use? YES NO
Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____
Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ Transgender__ In Question__

FAMILY:

How would you describe your relationship with your mother?_____

_____

_____

How would you describe your relationship with your father?_____

_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? ____. Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

POOR EXCELLENT
Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain: _____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment? _____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____

_____

What do you think are your strengths?_____

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		

Any additional information you would like to include:

_____

_____

_____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: __ MasterCard __ VISA __ Discover __ AMEX __ Other

Cardholder Name (as shown on card): _____

Card Number: _____ CVV Code: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (credit card billing address): _____

I, _____ , authorize _____ to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date