



Informed Consent to Treatment

Susanne Stribling, Psy.D., LLC

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Authorization and Consent to Treatment: I am pleased that you have chosen me as your treatment provider. I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association (APA). So that you will be prepared for therapy, you should know that psychotherapy has benefits and risks. Although it is an effective mode of treatment for a variety of problems, positive results cannot be guaranteed. In order for therapy to be successful, you will be expected to do work between sessions, which may include assigned homework or consultation with other treatment providers. Most often, we will meet in the office each week or every other week for 55-60 minutes. It is important that we form a collaborative relationship and that you feel comfortable sharing your needs and expectations. Additionally, because you will be discussing some unpleasant aspects of your life, it is important to recognize that you will likely experience some intense feelings. Not only is this normal, it is beneficial. If at any time I believe that therapy is not beneficial or other forms of treatment are required I will make a recommendation. If at anytime, you do not believe therapy is beneficial, please discuss this with me in session.

Fees: My fee for each 45-60 minute therapy session is \$135.00 and 75-minute sessions are \$165.00. First appointments and 90 minute sessions are billed at

the rate of \$185.00. Under extenuating circumstances, fees can be negotiated during time of service. I am an in-network provider with Health Partners Plans (Benefit Support and Alliant). If you are on another insurance panel I can provide you with a receipt for services so you can file for out-of-network benefits. Please let me know in advance if you are going to want your receipts for service. Any phone calls that last longer than 15 minutes will be charged at a pro-rated amount of \$2.00 per minute (20 minute phone call is \$40.00). Please know that insurance will not pay for phone calls. Fees are payable at the end of each session by check or cash (this includes your co-pay or coinsurance for insurance). If you are paying for the session in full, you may use a credit card.. A cancellation fee of \$85.00 will be charged to the credit card on file for appointments that are not cancelled within the 24-hour cancellation window. Appointments need to be cancelled with 24-hours notice of the appointment time. If your appointment is on a Monday, your appointment will need to be rescheduled or cancelled by 3pm the preceding Friday to avoid a cancellation charge. It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so you will be expected to pay the entire fee of 85.00 not just the co-pay you may normally pay, for missed sessions.

****For those with Health Partners, Alliant and Benefit support insurance only:** If you have mental health benefits through one of these insurance companies, I will bill your insurance directly for each of your sessions and be reimbursed directly by them for their portion. Accordingly, you are responsible for any co-pay, or deductible as stipulated in your plan. You can pay this at each session using cash or check. If you have not met your deductible you will be responsible for payment in full until your deductible is met. **It is your responsibility to understand your insurance benefits so check with your insurance provider about your mental health benefits prior to starting therapy. If your insurance company rejects claims for any reason, the fees are your responsibility.** Please note that insurance companies require some Protected Health Information to process claims. This can be demographic data, diagnosis, time and length of sessions, as well as treatment plans and session notes.

_____Initial

Your Session: Your session lasts 55-60 minutes. If you arrive late for your appointment time, we will end session at the scheduled end time, out of respect for other appointment times scheduled. During your 55-60 minute session time, it is expected that we discuss issues related to therapy, as well as scheduling, insurance questions, and billing. Therefore, if you know you have new billing information or

questions about the schedule, please discuss these items at the beginning of session. I prefer to set a “standing” appointment time for you, meaning you have a reserved hour on the same day each week or every other week. If you miss your appointment, I will plan on seeing you at your standing appointment time the following week, unless you notify me otherwise. If you miss 2 or more standing appointment times in a row, without contacting me, I will assume you have decided to end therapy and your appointment time may be offered to another client. As such, if no appointment has been scheduled within 30 days, without contact, I will assume you are terminating therapy, and I will close your file. If your schedule changes weekly, and a standing appointment time does not work for you, please let me know so we can do our best to find a time each week that does work.

_____Initial

Confidentiality: The law protects the privacy of all communication between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form, called a Release of Information (ROI), that meets certain legal requirements per HIPAA standards. Exceptions to confidentiality include; when a client expresses a serious intent to inflict life threatening harm to him/herself or another person; if you are currently unable to care for yourself which poses a risk of life threatening crisis; if you report child or elderly abuse. If child or elderly abuse is disclosed, I am required to make a report to the Department of Family and Children Services who may open a case based on this report. You can be a part of the case report if you would like. If you file insurance, your personal information, including diagnosis, dates of service, and at times a treatment plan and rationale for services provided are shared with your insurance company to process your claims. If you have concern about the type of information sent to your insurance provider please discuss this with me and I will answer any questions you have. There are also other possible limits to confidentiality. Court orders have been used to gain access to clients’ records in some cases.

_____Initial here to agree to have protected health information released to your insurance company for reimbursement purposes.

Consultation: In order to maintain ethical standards, I find it helpful at times to consult with other professionals. In these consultations, I do not reveal any identifying information about my clients. The consulted therapist/psychologist/psychiatrist or legal representative is also bound to keep any information about a case confidential by the ethical standards of his/her own

professional associations. I never consult with professionals who are not bound by such ethical standards.

_____Initial

Interaction with the Legal System: As your therapist, my role is to help treat mental health issues and/or help assist/support with life events, change, or difficult relationships. Involving the legal system at any point during the therapy relationship, often poses a conflict of interest. Therefore, I do not engage with legal issues or litigation during or after the therapy relationship. This would include any interaction with the Court system, attorneys, Guardian ad Litem, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. If you wish to have a copy of your file, and execute a proper release, that will be provided. Usually a fee of \$50.00 is associated with a records request, but may be more for an extensive case file. If there is a subpoena, there is an expert witness fee in the amount of \$1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of \$375.00 per hour including travel time. Please understand that with a subpoena, I may elect not to speak your attorney, and a subpoena may result in me withdrawing as your therapist.

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Emergency Procedures: I can be reached during regular office hours at 770-540-0610. Routine calls made between the hours of 9:30 a.m. and 5:00 p.m. Tuesday-Thursday will be returned within 24 hours. Routine calls received when I am not in the office may not be returned until the following business day. I do not provide emergency services, nor am I available at all hours. When I am on vacation or out sick, I will have a colleague available to see my clients if necessary. If an emergency arises, and you believe immediate attention is necessary, please call 911 immediately or report to your nearest emergency room. Alternatively, you may call the Georgia Crisis and Access line **1-800-715-4225 to speak with a trained clinician 24 hours per day, 7 days per week. They will provide mobile assessment as well, if needed. Other resources include** Ridgeview Institute at 770-242-4567 (Atlanta); or Peachford Hospital at 770-454-5589 (Atlanta), or Laurelwood Hospital (Gainesville) 770-219-2888 or 800-848-3649. If at any time you believe you are in need of more emergency care than I can provide now or at any time during therapy please discuss this with me so that an appropriate referral and an appropriate treatment plan can be arranged.

_____Initial

I, the undersigned, have read and understand the above information (Informed Consent) and I consent to treatment under these conditions. I understand I have the right to withdraw consent at any time, which results in the termination of treatment.

Name (please print): _____

Signature: _____ Date: _____

I further acknowledge that Susanne Stribling, Psy.D. has provided me with the Notice of Georgia Policies and Practices to Protect the Privacy of Your Health Information (HIPAA).

Name: _____

Signature: _____ Date: _____

ELECTRONIC CONSENT

While Susanne Stribling, Psy.D. takes reasonable precautions to protect your confidential information, e-mail and text messaging are not a completely secure method of communication. Because of limits to confidentiality, Dr. Stribling's phone does not accept text messages. If you attempt to cancel an appointment via text, you will be charged the cancellation fee since I do not receive text messages.

_____ Initials

I acknowledge that if I use electronic mail to initiate contact with Dr. Stribling regarding my therapeutic care, that Dr. Stribling has my permission to correspond via that email address and other forms of electronic communication.

The purpose of e-mail and other forms of electronic communication is to communicate with the client regarding scheduling appointments, reminding clients regarding their appointments, homework assignments, follow-up care according to staff or information regarding the clients' business account. Electronic communication is not a way of communicating new information regarding care or of communicating emergency treatment.

I give permission for Dr. Stribling to email me regarding my therapeutic care at:

_____ @ _____

_____ No Thanks. I had rather not provide my email address.

Name: _____ SIGNATURE: _____