APPLE VALLEY WELLNESS & COUNSELING SERVICES
3354 Apple Valley Road
Commerce, Georgia 30529
706-336-0049

OFFICE POLICIES AND CLIENT CONSENT FORM

Welcome to Apple Valley Wellness & Counseling Services. The following is a description of our general office policies and information designed to help you understand the wellness and counseling services we provide. Please read carefully and let us know if you have any questions.

Appointments and Fees

General office hours are 9:00 to 5:00 Monday through Friday and clients are seen by appointment only. Some of our therapists offer evening appointments. Each counseling session is scheduled to last fifty (50) minutes. Arriving on time is important to assure that you receive a full 50 minute session.

Fees for counselors are $79 per hour. We accept cash, checks and credit cards. Credit card users will be assessed a $2-3 courtesy fee for use of the card. There will be a $30 service charge for all returned checks. Payment will be made at the beginning of the counseling session. Payment is due when service is rendered. Any outstanding balance after ninety (90) days will be turned over to a collection agency.

Insurance

Apple Valley Wellness & Counseling Services is a self-pay service. Information will be provided for those who wish to file insurance themselves.

Telephone Consultation and Emergencies

It is understood that from time to time you may need to consult with one of the therapists briefly by telephone. For these necessary and brief consultations, there is no charge. However, if you wish further assistance, we can schedule an additional session or proceed with a phone session. Phone sessions will be charged at a pro-rated basis after the first five minutes. Cell phone or emergency numbers are provided by individual counselors. These are to be used prudently and with regard for the counselor's private life.

Children

Our goal is to provide a quiet, relaxed atmosphere for our clients during counseling and evaluation sessions. In consideration of other clients who are in session at the time, we ask that children who must come to the office be as quiet as possible while waiting. It is the responsibility of the parent or guardian for any children brought into the counseling office to be supervised by an adult in the waiting area. *Parents are strongly encouraged to leave children not directly involved in counseling sessions at home.*

Counseling For Children

The parent or guardian bringing a minor child in for counseling or evaluation services is responsible for payment of fees. In the event that the parents of the child are divorced and must each pay half of any medical bills, the parent bringing the child must pay the full amount due for services at the time of service. Upon request, receipts will be given to provide proof of payment.

PLEASE NOTE: If the parents of a minor child are divorced, information regarding the child and the counseling process can only legally be given to the parent who has legal custody of the child. Information concerning the minor child may be shared with both parents if the parents have joint legal custody of the child.

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Informed Consent

Counseling may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness or helplessness may also be aroused.

The benefit from counseling may be that you will be better able to handle or cope with your family or social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal hgoals and values; this may lead to a greater maturity and growth as a person.

You should know that therapists are not physicians and cannot prescribe or provide you with any drugs or medication or perform medical procedures. If ymedical treatment is indicated, a physician can be recommended for you.

Confidentiality Policy

Confidentiality is one of our main concerns in the practice of counseling and psychotherapy. For your protection, information about counseling and your records are held strictly confidential and cannot be discussed or released to anyone without your written consent. You will be asked to sign a release should it be necessary for Apple Valley Wellness and Counseling Services staff to discuss you or your child's case with another party. In the following circumstances, as deemed by your therapist, confidentiality will be broken:

- Disclosures to family members, the police, social service agencies and others may be made when there is sufficient cause to believe that you pose an imminent threat of physical harm to yourself or others.
- Necessary information will be released to family, law enforcement officials and other treatment professionals or hospitals in a life-threatening emergency.
- Mental health professionals are required by law to report to State officials any suspicion of abuse or neglect to a minor child, disabled or elderly person. Information necessary to make this report will be released in that event.
- If you have been court ordered to our office for an evaluation, information will be released to the Court and to the attorneys in the case, as required by law. However, you will be asked to sign appropriate releases so that you will be informed to whom information will be sent.

If you have any questions regarding the information above, ask your therapist for clarification.

Termination Policy

At the point in which the counseling relationship is terminated, notes will be placed in each patient's file reflecting both the reason for the termination as well as whether it was a mutual or unilateral decision o n the part of the client. If you request further treatment, three references will be provided for other practitioners for follow-up care. All clients will be reminded that the

counselors at Apple Valley Wellness & Counseling Services will be available for emergencies at any time.

Any unpaid balance at the termination of the counseling relationship will be the responsibility of the client.

I have read and understood the above policies, and agree to the financial arrangements outlined above.

Client's signature ____Date_____________

Therapists' signature_______________________________________Date____________

APPLE VALLEY WELLNESS & COUNSELING SERVICES

CLIENT INFORMATION FORM

Name: ____E-mail: _______________________

Address:____City, State, Zip:______________________

Home Phone: ________________________________ Cell Phone______________________________

Date of Birth: ___________________ Age: _________ Social Security #: ______________________

Employer: ____ Work Phone: __________________

Preferred phone number for contacting you: ____

Marital Status:Single Married Divorced Separated Widowed

Name of Spouse: ____Age: _________

Spouse's Employment: ____ DOB: _______________

Person Responsible for Payment: ____

(if other than patient) Address: ____

Home Phone: __________________________________ Work Phone: _________________________

List Children's Names and Ages:

Name: __________________________ Age: _____ Name:______________________ Age:______

Name: __________________________ Age: _____ Name: ______________________ Age: _____

Name: __________________________ Age: _____ Name: ______________________ Age: _____

Emergency Contact: ____

Phone Number: ___________________________Relationship: _______________________________

Who referred you to our office? ____

Church affiliation: ______________________________ Pastor: _______________________________

MISSED APPOINTMENT POLICIES

We value your time and participation in the counseling process. We want your counseling experience to be positive and helpful in all ways. Counseling is most effective when appointments are keep consistently. It is our pledge to meet with you for your appointment in as timely a manner as is possible and we expect for you to make all reasonable efforts to attend your appointment and to be on time.

When you schedule your appointment, you have reserved this time in our schedule and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 706-336-0049 ***at least 24 hours in advance***. This will allow our staff to contact clients on our waiting list and to offer them this appointment time. At some point in our counseling process you may be the beneficiary of such a fill-in appointment.

If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits, you will be charged our pay-in-full missed appointment fee of $79. The only exceptions to this policy are appointments missed due to last minute illness or emergencies.

Payment for missed appointments is due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay this fee at the time you check in for your next appointment.

You are responsible for remembering your appointment and attenting.

By making these policies clear to you, the client, any possible misunderstanding is eliminated should this situation occur in your counseling process. By signing below you are indicating that you have read, understood and agree to these conditions.

Client Signature: ____ Date: ____________________

Witness: ____Date: ___________________