Gail A. Phillips, LCSW

2734 N. Hills Drive NE
Atlanta, Georgia 30305
gail@gailphillips.net
(404) 982-9010

CONSENT FOR TREATMENT

PROFESSIONAL BACKGROUND:

I am a licensed clinical social worker. I have a master's degree in Social Work from the University of Southern California and a bachelor's degree from the University of Georgia. I have held licensure as a master social worker since 1988 and a clinical social worker since 1990.

COUNSELING PHILOSOPHY & EXPECTATIONS OF CLIENTS:

I believe all individuals have the capacity to thrive, and my job is to help you remove the roadblocks that are keeping you from thriving. I see our psychotherapy relationship as one in which ***you*** set your goals because you know what is best for you, and I am privileged to work with you to attain those goals. I take my job as your psychotherapist seriously and believe it is courageous of you to engage in this process. I expect you to be actively involved in our work together: to talk about whatever is on your mind and to share your past experiences, your dreams, your fears, your thoughts, your feelings and anything else that is meaningful to you. By doing so, you will uncover and attempt to work through whatever is preventing you from thriving. It is impossible to guarantee any specific results regarding psychotherapy. However, we will work together to achieve the best possible results for you. If we both agree to begin a psychotherapy relationship, we will sign, date, and keep a copy of this informed consent. I will be considered your psychotherapist until termination occurs.

MY PERSONAL STATEMENT & PHILOSOPHY:

I believe it is crucial for me to take very good care of myself physically, emotionally, psychologically, educationally, and spiritually. I do this in a number of ways: by taking time to rest, refresh myself, and renew my spirit; by taking time to be physically active and to exercise regularly; by taking time to attend professional and personal workshops; and by taking time to do other things that give me joy including being with the people I love, giving workshops, traveling, reading, and writing. It is my belief that being happy, healthy and thriving in life requires a balance between work and play, and I do my best to manage my life in ways that reflect this belief. Therefore, there will be times when I will not be available. Occasionally, I may be unavailable for 2 weeks at a time. I will inform you in advance when I will be unavailable and will provide you with the name and number of another psychotherapist you can contact if you feel the need to do so.

CONFIDENTIALITY & EXCEPTIONS:

Please understand that I will keep confidential anything you tell me, with the following exceptions:
1. You allow me to talk with someone else by signing a release of information.
2. I determine you are a danger to yourself or to others.
3. You abuse a child or an elderly or disabled person.

ETHICAL GUIDELINES & STANDARDS:

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards for licensed clinical social workers. For a copy of the code of ethics to which I adhere, you may contact the Georgia Composite Board for Licensed Counselors, Social Workers, and Marriage and Family Therapists.

FEES:

My fee is $200.00 for a 50-minute appointment. For extraordinary appointment length, telephone consultations, and written work my fee is prorated in keeping with the above rate. The fee for a returned check is the bank charge, plus $25. Payment for additional charges is due at your next appointment.

PAYMENT:

You may pay by check, cash, money order or credit card. If you chose to pay by credit card, there is a $5.00 processing fee and a credit card form to be completed.

APPOINTMENTS:

If you cannot keep your appointment time, please give me ***at least 24 hours notice*** (more is appreciated) so I can make the time available to others. If you cancel with less than 24 hours notice or you miss a scheduled appointment, you will be charged for the appointment. Please add the fee for that appointment to your payment for the next appointment. If you are going to be more than 20 minutes late for your appointment, please let me know by calling me at **(404) 982-9010** and leaving a message if you do not reach me directly. Otherwise, if you are more than 20 minutes late, I will assume you are not coming and I may be unavailable. If this happens, you will be charged for the missed appointment. Fees are not prorated if you are late.

INSURANCE:

I choose not to be an approved provider for any insurance or managed care companies. This decision is based on my concerns about their lack of confidentiality of your personal information and that treatment decisions are made by outside third parties who may not be qualified to make those decisions and who may not have your best interest in mind. The responsibility is yours for checking with your insurance company to determine if they will reimburse you for my services. My fee is still due from you at the beginning of each appointment. Please let me know if you would like a receipt for you to file with your insurance company.

TERMINATION:

Your decision to enter psychotherapy is voluntary and you may terminate at any time. Termination of the psychotherapy relationship is also a natural occurrence when your goals have been met. The psychotherapy relationship may also be terminated if, in my professional opinion, it is in your best interest for me to refer you to another psychotherapist, as ethical standards dictate this course of action. Choosing to continue psychotherapy with another psychotherapist is your decision. Termination will occur if I have not seen you in an appointment for 8 weeks from the date of our last appointment, unless you and I have a prior agreement to leave your case open for a specified amount of time.

CONSULTATION:

In keeping with accepted standards of practice and to ensure quality of care, I regularly consult with other mental health professionals regarding my work with clients. Client identity is protected at all times.

RECORDS:

Your records are kept for 7 years from the date of our first appointment. They contain my copy of this informed consent, your client information form, and all materials that pertain to you including my notes. It is confidential with the exceptions noted in the **Confidentiality & Exceptions** section. It is kept in a locked file cabinet and will be destroyed by shredding at the end of 7 years.

SIGNATURE:

Your signature indicates that you have reviewed this document, had your questions answered to your satisfaction, and that you agree to adhere to the policies specified in this document.

_____ _____

Client Signature Date