Gail A. Phillips, LCSW

gail@gailphillips.net ~ www.gailphillips.net
2734 N. Hills Drive, Atlanta, GA 30305
(404) 982-9010

CONSENT FOR TREATMENT (Minor)

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. We will work together to achieve the best possible results for you. By signing this agreement, I will be considered your psychotherapist until termination occurs.

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.

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.

FEES & PAYMENT:
My fee is $200.00 for a 45-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. 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.

INSURANCE:
I choose not to be on any insurance panels, please let me know if you would like a receipt for you to file with your insurance company.

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INTERACTION WITH THE LEGAL SYSTEM:
You understand that you will not involve or engage me as your therapist in any legal issues or litigation at any time either during your psychotherapy or after it terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system.

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.

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.

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.

PERMISSION TO TREAT MINOR:
For minors to receive psychological services, parent(s)/guardian(s) must grant permission. In instances of divorce with joint legal custody, permission is required of both parent(s)/guardian(s). In instances of divorce with sole legal custody, a copy of the court order designating custodial parent must be provided.

Name of minor_____ Date of birth_____

Name of person requesting services_____

Relationship to minor: ☐ Parent ☐ Step-parent ☐ Guardian

If divorced: ☐ Sole Custodian ☐ Joint Custodian

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CONSENT FOR TREATMENT (Minor)

Do you have legal right to obtain treatment for the above-named minor? ☐ Yes ☐ No

Please note that both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the minor child.

In signing this document, I am indicating my consent to allow Gail Phillips, LCSW, to provide counseling services to the minor named above. 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 (minor) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Revised July 2019