Laura B. Morse, MS, LPC, CPCS
2900 Chamblee-Tucker Rd., Building 8, Suite 200
Atlanta, GA 30341
678.469.7014

This information is provided so you will understand how I work. Please take the time to read this information carefully. Please talk with me about any concerns or questions you may have.

CONSENT AND CONFIDENTIALITY

By seeking therapy with me, you are consenting to treatment under the guiding principles for clinical practice established by the Georgia Composite Board of Professional Counselors. You may terminate your consent for treatment at any time. Your therapy and related records are held confidential and protected by law with the exception of court order, suspected child or elderly abuse, or threat of harm to self or others.

TARASOFF WARNINGS

Under Georgia law, when a client makes what a counselor considers to be a legitimate threat toward a third party, the counselor must warn the identifiable potential victim, if there is one (there is no requirement to attempt to warn a whole class of people) and the nearest police department. A verbal warning should be made to the intended victim. The therapist should also fully document the warning to the intended victim in the client's case record. If the victim cannot be reached by phone or in person, a letter should be sent to the intended victim by registered mail, return receipt requested. If there is any question regarding the intended victim understanding or taking the threat seriously, a follow-up letter, return receipt requested is also suggested. The initial report to the police may be oral but should be followed by a written report, generated by either the police or the therapist.

MANDATED REPORTING ISSUES

In Georgia, as in most states, all licensed mental health professionals are mandated to report abuse and neglect of children under age 18, abuse and exploitation of disabled persons, and abuse and exploitation of persons over the age of 60. Counselors can call the appropriate agencies and describe a questionable situation and be advised as to whether it needs to be reported.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/ she may have.

APPOINTMENTS

Appointments are made with me directly and become a time set aside for you. Sessions are 50 minutes long. Additional fees will be charged for extended sessions.

If you cannot keep your appointment, notify me as soon as possible. The time set aside for each individual makes it necessary that a regular charge be made for appointments not canceled a full 24-hours in advance. The reason for cancellation does not affect this charge**.**

Notice to insured or managed-care clients: If you miss a scheduled appointment, and fail to cancel it 24 hours in advance, you will be charged the full fee for that session, not just your co-pay amount. Insurance does NOT pay for missed sessions.

USING INSURANCE AND INSURANCE REIMBURSEMENT

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf. I will not file insurance for out of network services. I will instead, provide you with the appropriate information so that you may submit charges directly to your managed care company.

USING INSURANCE AND INSURANCE REIMBURSEMENT CON'T

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. You may call your insurance company to discuss how your counseling information is protected specifically by your insurance carrier. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

FEES

Unless other arrangements are negotiated, full payment is requested at the time of each visit. **I accept personal checks,cash and credit/debit cards**. Any returned checks would result in a $25.00 charge. If your account is overdue and you have not arranged a payment plan with me, I may use legal means to obtain payment. In that case, you will be responsible for any fees incurred in the process. Interest may be charged on overdue accounts.

AFTER HOURS AND EMERGENCIES

I check voice-mail several times during the day and will return calls until 9:00pm. If you need assistance before I get back to you because of a crisis (involving a threat to harm self or others), you can call the 24-hour mental-health crisis line in your county or 911. Also, you can call the nearest hospital to you and ask for the psychiatrist on call. If I become unavailable for an extended period of time, an experienced colleague will be available for emergency calls.

I have read and agree to these treatment terms. I give consent to receive treatment from Laura B. Morse, MS, LPC

Client Signature_____ Date_____

Client Information Sheet

Date:_____
Name of Client_____
Name of Parent (if client is a minor)_____

Address _____

_____

Work Phone: _____ Employment:_____

Cell Phone: _____

Home Phone: _____

Occupation:_____ Email: _____

Date of Birth _____

Party Responsible for Payment and Address if not living with you:
_____
_____

In Case of Emergency Contact: _____

Relationship to Client _____

Phone: _____

Referral Source: _____

Relationship to Client:_____

IF AN INSURANCE COMPANY WILL BE RESPONSIBLE FOR PAYMENT FOR YOUR COUNSELING SERVICES, PLEASE ANSWER THESE QUESTIONS AND SIGN BELOW:

Insurance Co._____
Name of Insured_____
Date of Birth of Insured_____
Ins. Co.
Address_____

Policy #_____ Insurance ID #_____

Phone # to Verify Benefits_____

AUTHORIZATION AND ASSIGNMENT OF INSURANCE:

I authorize Laura B. Morse, LPC to furnish information to my insurance carrier concerning my diagnosis and treatment.

_____ Signature Date

I assign Laura B. Morse, LPC all payments for services rendered to me/my dependents. **I understand that I am responsible for any amount not covered by assigned insurance. This includes missed or cancelled sessions where less than 24 hours notice is given to provider.**

_____ Signature Date

(A PHOTOCOPY OF THIS AUTHORIZATION AND ASSIGNMENT WILL BE CONSIDERED AS VALID AS THE ORIGINAL.)