Laura B. Morse MS, LPC, CPCS
2900 Chamblee Tucker Road
Building 8, Ste. 200
Atlanta, GA 30341
LauraMorse.com
LauraMorseLPC@gmail.com
678.469.7014

Information, Authorization and Consent to Treatment

Thank you for selecting me as your therapist. Please know that I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me, policies regarding confidentiality, TeleMental health, emergencies, and several other details regarding therapy. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments or suggestions regarding your course of counseling at any time.

Professional Background

I received my bachelors of science degree in psychology from Spelman College in 1992 and my master's degree in Community Counseling from Georgia State University in 1996. I have been licensed as a LPC in the state of Georgia since December 2000 (GA3301). I have practiced in various clinical settings to include community mental health, residential treatment for substance abuse recovery, hospital/acute care and currently, private practice settings. In addition to my counseling work I am also a certified professional counseling supervisor (CPCS #235) and provide clinical supervision to Associate Licensed Counselors who are working towards full licensure with the Georgia State Composite Board.

Confidentiality and Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically on a HIPAA approved website specifically designed for mental-health clinicians. Additionally, I will always keep everything you say to me confidential with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or others; in which case I will sign a legal emergency transport order to the nearest receiving facility (known as a "1013") (3) you report information about the abuse of a child, an elderly person or a disabled individual who may require protection; or (4) I am ordered by a judge who has legal jurisdiction over me to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged

communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal with be sustained, but I will do everything in my power to keep what you say confidential. Please note that in couples counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner. In addition, if you agree to participate in couples counseling, I will not release any information/records without legal permission from both partners regardless of whose name is primary on the record/chart.

Interaction with the Legal System

I do not see clients who have any pending legal matters whether criminal, civil, domestic or in any other manner. If you choose to participate in counseling with me, you are legally agreeing not to involve or engage me (Laura B. Morse) in any legal issues or litigation in which you are a party to at any time either during your counseling or after your counseling terminates. This includes any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that you wish to have a copy of your file and have executed a proper release, I will provide you with a copy of your records and you will be responsible for any costs incurred in that process. If I as the therapist do end up having to testify via a valid subpoena, you will be responsible for my expert witness fees in the amount of $1500 per day due 5 days prior to the initial appearance or deposition. Any additional time will be billed at $350 per hour including travel time. Should you subpoena me, I may elect not to speak with your attorney and a subpoena may result in termination of the therapeutic relationship and me withdrawing as your therapist.

TeleMental Health

TeleMental Health is defined as follows: “TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers.” (Georgia Code 135-11-.01)

I am trained and certified in the State of Georgia as part of my licensure to provide telemental health communications within the state. The laws apply to the state where the client is located at the time of service.

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special

technology. Individuals who have access to your telephone or your telephone bill may be able to determine whom you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Additionally, I keep your phone number in my cell phone and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging/Email:

Text messaging and emailing are not secure means of communication and may compromise your confidentiality unless they are done via a HIPAA-approved encrypted app. I realize that many people prefer to text and email because it is a quick way to convey and receive information. **Nonetheless, please know that it is my policy to utilize these means of communication strictly for appointment confirmations or questions.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts and emails as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, Snapchat etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

Search Engines (Google, etc.):

It is my policy not to search for my clients on ANY search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me, as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session unless we are communicating via a HIPAA approved encrypted app.

Video Conferencing (VC):

I will use a HIPAA approved video app (unlike FACETIME) as an acceptable means for counseling sessions IF telehealth is an appropriate and safe method of communication. This will be an ongoing assessment based on clinical/ethical evaluations. At this time I use Doxy.me for telehealth counseling sessions.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage:

At this time I do not use electronics records storing platforms. All notes/records are stored in a securely locked file in a securely locked office. **Law requires that adult records are stored for 7 years from the last date of service (10 years for clients under the age of 18). If I choose to use an electronic recording system, I will notify you of this change and obtain updated consent.**

Electronic Transfer of PHI for Certain Credit Card Transactions:

I utilize Square and STRIPE as the companies that processes your credit card information. This company may send the credit cardholder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways —either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as *Laura B. Morse, LPC.*

Your Responsibilities and TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Structure and Cost of Sessions

I agree to provide individual psychotherapy for the fee of $150 for the initial intake session (90 minutes), $120 per 50 minute individual sessions and $200 for 90 min couples counseling or $150 for 50 minute couples sessions. The fee is due at the end of each session. Cash, credit/debit cards are all acceptable forms of payment. Upon payment a receipt will be emailed/texted to you. It is your responsibility to understand your insurance company’s policies and to file for insurance reimbursement. A “superbill” will be available to you (upon request) which contains all of the necessary information for you to submit for possible reimbursement from your insurance company.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received you will be financially responsible for the full cost of the missed session.

In Case of an Emergency

My practice is set up to accommodate individuals who are reasonably safe and resourceful. I am not available at all times. If at any time this does not feel like sufficient support, let me know and additional resources and options can be discussed. Generally, I will return phone calls within 12-24 hours. If you have a mental health emergency I encourage you not to wait for a call back, but to call 911, go to your nearest hospital emergency room, call the Georgia Crisis & Access Line at 1-800-715-4225 or go to www.mygcal.com for more information.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in other ways, we would then have a “dual relationship” which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist’s interests and the client’s interests, and then the client’s (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist’s responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as I would like to, for your protection I will not address you in public unless you speak to me first. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In summary, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

Non-recording Agreement

Successful therapy depends on building a relationship of trust, good faith and openness between client and therapist. Audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room. In addition, recordings can be made and taken home by clients and fall into unintended hands through loss, random or targeted theft or action by the police or other government agencies. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give your recordings all of the legal confidentiality they give to a therapist’s notes and may find them self-serving and as a result, the recordings may be a source of conflict in pending legal cases. In addition, once a recording is made, it cannot be deleted legally if a subpoena is issued and doing so is legally

punishable. As a result of the above information, recordings undermine the therapeutic process and the building or rebuilding of trust.

Statement Regarding Ethics, Client Welfare and Safety

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, along with your participation, I will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, others may not always welcome an increase in assertiveness. It is my intention to help you manage the changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work best for you, help is generally on the way.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document please ask.

My Personal Statement and Philosophy about Being a Therapist

I believe it is crucial for me, as a therapist, to take very good care of myself physically, emotionally, psychologically, educationally, and spiritually. I do this in a number of ways, such as choosing to take time to rest, refresh myself, and renew my spirit by attending professional and personal workshops, and by doing things other than therapy that give me joy; such as being with the people I love, traveling, reading and teaching. It is my belief that work is not the most important thing in life and I do my best to practice what I preach by taking care of myself in ways that reflect this belief. All of this means that there will be times when I am not available in which case I will provide you with the name and number of another therapist you can contact if you feel the need to do so.

Laura B. Morse, MS, LPC, CPCS (Separate notice)

GENERAL AND TELEBEHAVIORAL HEALTH INFORMED CONSENT

I agree to participate in technology-based consultation and other healthcare-related information exchanges with Laura B Morse, A LICENSED PROFESSIONAL COUNSELOR. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment. It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app").

(YOU understand that a variety of alternative methods of behavioral health care may be available to you, and that you may choose one or more of these at any time. Your behavioral health care provider has explained the alternative to your satisfaction.)

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

My health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

(You understand that it is your duty to inform your practitioner of electronic interactions regarding your care that you may have with other health care providers.)

In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from my practitioner and I. Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

(In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.)

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

I understand that my telebehavioral consultation(s) may be recorded and stored electronically as part of my medical records.

I understand that I am not entitled to royalties or to other forms of compensation for participation in any telebehavioral consultation(s) or other information exchange.

I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable). I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

I unconditionally release and discharge Laura B Morse, MS, LPC, CPCS from any liability in connection with my participation in the remote consultation(s).

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

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TeleMental Health Authorization and Consent to Treatment
Signature Page (please sign and return to therapist)

Please print, date and sign your name indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you.

Client Name (Please Print) Date

Client Name Signature Date

If Applicable:

Parent or Legal Guardian (Please Print) Date

Parent or Legal Guardian Signature Date

Referred By

In the case of an emergency, these are my trusted contacts that I would like you to call

Name Telephone Number

Name Telephone Number

My signature below indicates that I have discussed this form with you and answered any questions you have regarding this information.

Therapist Signature Date

LAURA MORSE LICENSED PROFESSIONAL COUNSELOR

Client Information Sheet

Date

Client Name | Date of Birth

Name of Parent (if client is a minor)

Address

Home Phone | Cell Phone | Email

Work Phone | Place of Employment | Occupation

Party Responsible for Payment and Address if not living with you

In Case of Emergency

Contact Name | Relationship to Client | Phone

Referral Source | Relationship to Client