



Describe any physical problems you have that require medication or physical care: \_\_\_\_\_

Are you currently receiving medical treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

When did you last consult with your primary care physician? \_\_\_\_\_

Are you currently taking any prescription medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list by name and dosage: \_\_\_\_\_

Previous Counseling/Therapy Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

With whom? Name \_\_\_\_\_ Address: \_\_\_\_\_

Briefly describe the problem which prompted you to seek counseling now: \_\_\_\_\_

Have there been times when the problem got better or disappeared? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_

What do you think helped? \_\_\_\_\_

Were there times when the problems were especially bad? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_

What made it bad? \_\_\_\_\_

Are there other people who play a major role in causing your problems Yes \_\_\_\_\_ No \_\_\_\_\_ or in helping you cope with your problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain briefly: \_\_\_\_\_

Is there anything else that you believe might be important for your counselor to know at this time? \_\_\_\_\_

**Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
No Concern					Moderate Concern					Extreme Concern
_____										_____
										Religious/Spiritual Concern
_____										_____
										Sexual Concerns
_____										_____
										Thoughts of suicide
_____										_____
										Trouble making decisions
_____										_____
										Unhappy most of the time
_____										_____
										Use of alcohol
_____										_____
										Use of alcohol by family member
_____										_____
										Use of other drugs
_____										_____
										Use of other drugs by family member
_____										_____
										Work
_____										_____
										Worry
_____										_____
										Sleeping Difficulties
_____										_____
										Other (specify) _____

**A survey may be mailed to you upon the completion of your counseling experience at the center. Please indicate your preference in the appropriate box below.**

**You may send the survey.**

**Do not send the survey .**

## ***Horizon Counseling & Consulting, LLC***

BARBARA D. CARLIN, MA, LPC, NCC, RYT 200  
11385 BIG CANOE  
BIG CANOE, GEORGIA 30143  
Phone: (404) 293-1113 | E-mail: [bcarlin@horizonatlanta.com](mailto:bcarlin@horizonatlanta.com)

### **INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT**

I am very pleased that you have selected me to be your psychotherapist, and I am sincerely looking forward to assisting you. This document is designed to inform you of what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is an ethical obligation of my profession, it is more importantly a commitment from me to you to keep you fully informed of every part of your therapeutic experience. Your relationship with me is a collaborative one, so I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

#### *Background Information*

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. I am a LPC (Licensed Professional Counselor) and NCC (National Certified Counselor). I received my Bachelor of Arts in Education and Fine Art from Upsala College in East Orange, New Jersey and my Master of Arts in Professional Counseling from Psychological Studies Institute (now Richmond Graduate University) with a specialization in spiritual integration.

#### *Theoretical Views*

As a counselor, I believe that people are better able to find peace and contentment in their lives as they become more aware and accepting of themselves. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy.

Furthermore, it is my policy to see only clients who have the capacity to resolve their own problems with my assistance. I aim to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic environment does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. If at any time you believe that seeing another therapist would be more productive than seeing me, please let me know. The goal of therapy is to facilitate healing and growth,

and I am committed to helping you in the most constructive ways — even if that means referring you to another counselor.

### *Client Participation*

As a client, you are in complete control of the counselor-client relationship. Accordingly, you may end your relationship with me at any point. In addition, in order for therapy to be most successful, it is important for you to take an active role. This means that you must: (1) work on the things we discuss both during and between sessions; and (2) avoid any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

### *Confidentiality & Records*

Your communications with me will become part of a clinical record of treatment and will be referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office and will be kept completely confidential, with the following exceptions: (1) you direct me to tell someone else and sign a “Release of Information” form; (2) I determine that you are a danger to yourself or others; (3) you report information about the abuse of a child, elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose otherwise confidential information. In the latter case, my license allows me to uphold what is legally termed “privileged communication” — which refers to your right as a client to have a confidential relationship with a therapist. The State of Georgia has a very good track record of respecting this legal right. Yet, if for some unusual reason a court were to order the disclosure of your private information, you may appeal the court’s order. Any such appeal may or may not be successful; I cannot guarantee how a court will rule.

### *Confidentiality in public settings*

Therapists are required to keep the identity of their client’s secret. Therefore, in order to preserve your confidentiality, I will not address you in public unless you speak to me first (even though I might like to). I also must decline any invitation to attend gatherings with your family or friends.

### *Court and other legal matters*

I am not trained in forensic psychology, and therefore am unable to testify or give opinions pertaining to legal matters. If you believe that may be necessary, please discuss it with me at your first session. In order to preserve and protect the established therapeutic alliance established, it is my policy to refrain from any legal proceedings of any kind at any time. Additionally I will not speak with any court personnel.

## *Professional Relationship*

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me will likely be different than most relationships you have. For example, our relationship may differ in how long it lasts, in its objectives, or in the topics it addresses. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, we would then have a “dual relationship.” A dual relationship is problematic because: (1) it can be harmful to you; and (2) it is considered unethical by the mental health profession. Dual relationships can create conflicts between the therapists’ 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 focused purely 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, and want to find quick and easy solutions to your problems so that they can feel helpful. But these short-term solutions may not be in your long-term best interest. Further, friends do not usually follow up on their advice to see whether it was useful. In contrast, a therapist offers you choices and helps you choose what is best for you based on tested theories and methods of change. A therapist helps you learn how to solve problems better and make better decisions. Because of the unique relationship a therapist and client have, I will not be able to be a friend to you like your other friends after your therapy is completed. Moreover, I will not be able to participate in *Facebook*, *LinkedIn*, and the like, in order to protect your confidentiality and preserve the therapeutic relationship. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way but to provide you with long-term protection.

## *Structure and Cost of Sessions*

I provide psychotherapy for the fee of \$190 per 50 minute session, \$260 per 90 minute sessions and/or \$75 per 90 minute group therapy session. Needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore the idea of adding sessions or developing other resources that will help you. Telephone calls that exceed 10 minutes in duration will be billed at \$3.00 per minute. The fee for each session will be due at the conclusion of the session. Charge cards are acceptable and convenient forms of payment, and, upon your request, I will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company’s policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

### *Cancellation Policy*

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance (because that time has been reserved for you). If such advance notice is not received, you will be financially responsible for the session you missed. Insurance companies will not reimburse you for missed sessions. Moreover, if I miss an appointment without giving you 24 hours notice, I will pay you my full fee for that time (because you also saved the time).

### *In Case of an Emergency*

My practice is an outpatient facility. Accordingly, it is designed to accommodate individuals who are reasonably safe and resourceful. It should be noted that I do not text and am not available at all times. If at any time you do not feel that you are receiving sufficient support, please inform me so that we can discuss alternative arrangements, including, but not limited to, transferring your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls and emails within 24-48 hours. If you have a mental health emergency, do not wait for me to return your phone call. Instead, do one or more of the following:

Call Ridgeview Institute at (770) 434-4567  
Call Peachford Hospital at (770) 455-3200  
Call 911 or  
Go to your nearest emergency room.

**EMAILS OR TEXTS SHOULD NEVER BE USED TO COMMUNICATE EMERGENCY INFORMATION TO YOUR THERAPIST, as texts and emails may only be checked periodically throughout the week.**

### *Special Rules Concerning E-mail and Text Communications*

Emails to your therapist should be limited to the exchange of journal entries, dream entries, and appointments or appointment changes.

Please do not email or text me any information related to the content of your therapy sessions because engaging with me this way could compromise your confidentiality. Emails and texts are not completely secure. If you choose to communicate with me by email, be aware that all emails may be retained in the logs of your Internet service provider and my Internet service provider. Additionally, I am required to copy all emails and keep as part of your file.

Technology is constantly changing and there are therapeutic implications that we may not fully realize as of yet. My goal is to protect your confidentiality and to treat you with respect and dignity. Please feel free to ask questions and discuss your feelings about this important and ever changing topic.

## *Telemental Health Services*

Online psychotherapy, also known as a Telemental Health Services (“Telehealth”), involves a therapist or counselor, providing psychological counseling and support over the Internet through videoconferencing or phone calls. The information may be used for diagnostic impression, therapy, follow up and or education. Additional support materials may be sent via email for continued exploration and self discovery. During the course of treatment, I may also recommend you visit certain websites or utilize apps for the purpose of enhancing growth and change.

It is important for clients to remember to be in a space that ensures privacy and confidentiality when engaging in Telemental Health services.

## *Expected Benefits of Telemental Health Services*

Recent research indicates that Telemental Health services offer many benefits:

Improved access to mental health services by enabling the client to remain in his/her home or other remote site. It is important to note Therapists can only provide services in the state in which they are licensed.

Mental health services are more accessible and convenient - increasing mental health treatment outcomes.

Telehealth provides continuity of mental health services.

## *Possible Risks of Telemental Health*

There are potential risks associated with the use of Telemental Health Services. These risks include, but may not be limited to:

In rare cases, information, transmitted, may not be sufficient to allow for appropriate decision making by the therapist.

Delays in evaluation and treatment could occur due to deficiencies or failures of equipment or Internet connections.

And very rare instances, security protocols could fail, causing a breach of privacy of personal information.



*Statement Regarding Ethics & Client Welfare*

My services will be rendered in a professional manner consistent with the ethical standards set forth by the American Counseling Association and the Georgia Composite Board for Professional Counselors. If at any time you feel that I am not performing in an ethical or professional manner, please let me know immediately. If we are unable to resolve your concern, I will provide you with the contact information of the Georgia professional licensing board (which is the board that governs my profession) so that you can contact them.

Due to the nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we 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, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

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 the best for you, help is generally on the way.

*Conclusion*

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.

Please print, date, and sign your name below indicating: (1) that you have read and understand the contents of this form; (2) that you agree to the policies of your relationship with me as your therapist; and (3) that you are authorizing me to begin treatment with you.

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information. Please initial each page of this six page document.

\_\_\_\_\_  
**Therapist's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Signature**