Private Counseling

Bree Winkler, LPC, Ed.S., CAMS-II
5950 Crooked Creek Road
Suite150-C
Peachtree Corners, GA 30092
PrivateCounselingGA@yahoo.com
470-336-2884
www.PrivateCounselingGA.com

ORIENTATION TO SERVICES, POLICIES, PROCEDURES, and FORMS

I would like to take this opportunity to welcome you and thank you for choosing Private Counseling! Bree Winkler LPC is the sole therapist in this practice. This document provides information to let you know what to expect from your experience with me. My goal is to help you feel better and to do better in your daily life. Success cannot be guaranteed with counseling; however, I am committed to helping you function more effectively and confidently by learning how to cope with changes and the struggles of daily life. I welcome you to begin your therapeutic journey with me today!

INFORMED CONSENT

COMPETENCY AND SCOPE OF PRACTICE

- Licensed Professional Counselor (#GA005623)
- School Counselor (Certified PK-12)
- Telemental Health (renewed 2019)
- Certified Anger Management Specialist (CAMS-II)
- Prepare/Enrich premarital and marriage counseling (trained and certified)

Bree Winkler is a Licensed Professional Counselor in the state of Georgia. In my private practice, I provide mental health services to clients. My specialization is in Depression, Anger Management, Anxiety, and Relationship concerns. I am qualified to work with individuals (adults and adolescents) and couples who are confronting various personal, emotional, social, and behavioral issues. Therapy will focus on integrating Cognitive Behavioral Therapy with Psychodynamic Therapy to create a healthy therapeutic relationship between the client and the counselor.

RISKS AND BENEFITS

Therapy is a process. There is not a guarantee to "fix" problems. There are several treatment options and theoretical approaches to identify, diagnose, and treat clients. It is important to find a therapist who is empathetic, ethical, and professional. It is your duty as a client to find a therapist that is helpful to you. Effective therapists should challenge you within the framework of their therapeutic focus, while also keeping you safe. As a Cognitive-Behavioral therapist, I will challenge your maladaptive thought processes and give you homework assignments to practice thought and behavioral changes. Positive changes will not occur if you are not committed to making changes and/or disagree with my therapeutic orientation and approach.

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NATURE OF COUNSELING

I provide a safe and comfortable therapeutic environment for individuals and couples. I help clients work through their struggles effectively and at their own pace. I teach life skills and appropriate coping strategies. I will explore the individual's feelings, thoughts, behaviors, and perceptions and help them understand how their behavior is directly related to their views on self, others, and the world. I will encourage individuals to discover fresh solutions and to find ways to have a more satisfying and rewarding personal life. Counseling is not a guarantee to fix all problems. Counseling with me is a process to begin to change maladaptive thoughts and behaviors so you can feel better. Therapy is a partnership between counseling and client.

MISSION

I believe therapy should be a Holistic approach to healing the entire person. I will utilize Cognitive Behavioral Therapy and Psychodynamic Therapy to create a partnership between the client and the counselor. My mission is to maximize client satisfaction by providing quality therapy in a compassionate and respectful manner.

CONSUMERS RIGHTS AND RESPONSIBILITIES

As a client of Bree Winkler – Private Counseling LLC, you are entitled to:

1. Services in accordance with standards of professional practice, appropriate to your needs; designed to give you a reasonable opportunity to improve your condition;
2. Humane care, which includes being treated with dignity and respect;
3. Confidential maintenance of all your protected health information (PHI);
4. The right to register complaints and to have your complaints heard and action taken by contacting: Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists @ 237 Coliseum Drive, Macon, GA, 31217-3858 or (478) 207-2440) or http://sos.ga.gov/plb/counselors

RECORDS AND CONFIDENTIALITY

Discussions between a therapist and a client are confidential. Clients are not permitted to record any part of counseling interactions (including electronic communication). No information will be released without the client's written consent unless mandated by law. Possible exceptions include, but are not limited to the following situations:

1. I determine you are a danger to yourself or others.
2. I am ordered by the court to disclose information.
3. You (or parent/legal guardian) sign a written consent.

All interactions with your therapist will be part of your client file (including email, text, consultations, and attachments). Records will be destroyed seven (7) years after the termination of the therapeutic relationship.

Your records will be accessed by clerical personnel and/or the executor of my will, as clinically necessary. This includes billing, insurance claims, making copies per your written request, communicating/transferring information to other pertinent health professionals, and other indirect therapeutic assistance. All contact with your records will be handled ethically and confidentially.

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DUAL RELATIONSHIPS and BOUNDARIES

This refers to any situation where multiple roles exist between a therapist and a client, such as friends, family, or colleagues. This includes personal social media and interactions within the community. Dual relationships will be **avoided** to protect the therapeutic relationship and environment.

CONTACT INFORMATION

If there is an emergency, call Dekalb crisis center at (404) 294-0499 or Georgia Crisis Access Line at (800) 715-4225, **call 911**, and/or go to the local emergency room.

As a client of Bree Winkler, you have direct access to me for non-emergency situations. Messages may be left on my confidential voicemail anytime at 470-336-2884. You may also send me an email at privatecounselingga@yahoo.com or text me for questions, concerns, or appointments. I will respond to any messages within 24-48 hours.

APPOINTMENTS

Your appointment time has been reserved for you and you are encouraged to arrive on time. If you do not attend your scheduled appointment, or you cancel less than 48 hours in advance of your scheduled appointment time, you will be billed the cancelation fee. Appointments can be scheduled/canceled via email. All face-to-face sessions will occur in my office located at 5950 Crooked Creek Road, Suite 150-C, Peachtree Corners, GA 30092.

THERAPY SESSIONS

In-take Assessment: Initial visit will last approximately 50-60 minutes. During this session, I will obtain the family history, background, and reason for referral. If the referral is for a minor child, caregiver will provide information and any concerns the caregiver may have will be answered. I will obtain information from you to assist in making a diagnosis, developing a treatment plan, and making recommendations for return visits. You may also be referred to a psychiatrist or your Primary Care Physician for medication evaluation, if I determine that medication and/or medical exams may be helpful in addition to therapy. At the end of the session, the counselor will provide recommendations for therapy; it will be helpful for you and the therapist to discuss and decide on the options you want to pursue.

Follow-up appointments are aimed at working toward established goals and discussing behavioral changes that should be practiced between visits. Sessions are approximately 45-50 minutes per session.

Environment: Privacy and comfort will be provided in the therapeutic environment. Phones must be turned off. Parents/Guardians MUST be present for any session with a minor; however, individual sessions are private and parent/guardian can wait in the lobby, unless requested to participate in the session. Sessions will begin and end on time.

REFERRALS TO ANOTHER COUNSELOR

If at any time, for any reason, you are dissatisfied with my services, please let me know. Should you and/or I believe a referral is needed, I will offer suggestions on referrals. You are in

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complete control and may end our counseling relationship at any point. If you decide to terminate therapy, please notify me in advance, as it is best to properly terminate the therapeutic relationship. I do not guarantee the services of another practitioner or attempt to oversee his or her work. You are responsible ultimately for selecting and evaluating the services of any other practitioner.

In addition, I reserve the right to terminate our therapeutic relationship and refer you to another counselor at any time.

TELEMENTAL HEALTH

Online therapy (Telemental Health) has been approved by Georgia as an appropriate and effective mode to deliver mental health therapy. There are two categories of online therapy: Synchronous (real-time) and Asynchronous (non-real time). For mental health therapy with Bree Winkler LPC, synchronous therapy options include video platforms and phone conversations. Whereas, asynchronous therapy options include email and texts.

ADVANTAGES of TELEMENTAL HEALTH THERAPY

- No need to incur transportation costs for therapy sessions
- Time management and time savings
- Convenience and flexibility of location
- Prepay for sessions online
- Quality of psychotherapy is the same as face-to-face sessions

DISADVANTAGES of TELEMENTAL HEALTH THERAPY

- Limitations of confidentiality and privacy
- Potential technology difficulties
- Client comfort and ease of technology usage
- Lack of visual and/or auditory cues (depending on the modality used)
- Insurance companies may not approve payment for Telemental Health services
- You must be a GA resident and physically located in GA during sessions

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FORMS to COMPLETE

Located at www.PrivateCounselingGA.com under "Forms" tab.

- Adult **or** Child Information Form
- Informed Consent (below)
- Electronic Communication Consent (below)
- Fee Policy (below)
- Insurance Information (below, if applicable)
- Release of Information
- Prepare/Enrich for premarital or marriage counseling (if applicable)
- Safety Contract (if applicable)

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Informed Consent to Treatment

I, ____, voluntarily agree to receive mental health treatment and authorize therapist, Bree Winkler LPC, to provide such care, treatment, or services that are considered necessary and advisable for me and/or my minor child. I have thoroughly read and understand the **Informed Consent documents** provided. If I have any questions or concerns, I will speak directly with my counselor, Bree Winkler LPC.

I understand that I am consenting and agreeing only to those services that Bree Winkler LPC is qualified to provide within the scope of her professional license, certifications, and trainings. I understand that there are no guarantees regarding the services that I will receive. I agree to the terms and conditions as outlined in this informed consent document.

_______________________________________ _______________________ ______________

Client/Guardian Signature Relationship to Client Date

Electronic Communication and Usage

Be aware that text and e-mail messages are not encrypted and that they can be intercepted or misdirected, which means that your privacy and confidentiality cannot be guaranteed.

___ I understand that Bree Winkler LPC and Private Counseling is **NOT** a 24-hour crisis support. I understand if I am having a medical/mental health emergency, I must contact **911** or GA Crisis & Access Line (**800-715-4225**) instead of text/call/email to Bree.

___ I consent to communicating via non-encrypted **email** at the following email address: ____@__________________________

___ I consent to communicating via non-encrypted **text** messages at # __________________

___ I understand it is unlawful and unethical to **Record** all or part of my sessions without advanced written approval by therapist and client. Violation of this policy will result in termination of therapy.

___ I understand that by choosing Telemental Health for therapy sessions, confidentiality is limited by the encryption of the software and by client's choice to utilize the video session privately.

___ If choosing Online Therapy for therapy sessions, I understand that technology problems may arise. Client will work with Bree to determine the appropriate alternatives to sessions.

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Policy Agreement for Private Counseling

Client Name: ____ Date: ________

FINANCIAL TERMS AND FEES

I accept cash, check, or credit card for payment. **If** paying by check or cash, please **have payment ready prior to session**.

- The **initial assessment fee is $140 for a 50-60 minute assessment**. ______ Initial
- My fee for service is **$120 for each 45-50 minute therapy session**. ______ Initial
- Telemental Health sessions **must be pre-paid** via stored credit card. ______ Initial
- Phone Consultation is **$75/30 minutes** will be billed to your card on file. ______ Initial
- Card (credit, debit, HSA) processing fee is **$5/transaction**. ______ Initial

Insurance (Aetna or Anthem BCBS only)

Your payment will be your verified co-pay or co-insurance through your insurance. **You are responsible** for knowing the terms of your insurance. **You are responsible** for paying any portion of service that a) fulfills your co-pay or co-insurance, b) is applied towards your deductible, and/or c) your insurance does not cover. **Services not covered by your insurance will automatically be billed to your credit card**. ______ Initial

Payment Authorization for Insurance

I, ______________________________ (name), authorize Anthem **or** Aetna to release of any medical or other information necessary to Bree Winkler LPC to process this claim. I consent to behavioral health therapy and authorize the submission of claims and payment of benefits to Bree Winkler LPC for psychotherapy services that have been rendered to me.

Signature____ Date _____________

Insurance Company ___________________ Member #: ____________________________

Date of Birth: ______________Phone # for Provider (on back of card): ___________________

Cancellation/Missed Appointment Fees: Scheduled appointment times are reserved especially for you. If you **miss** an appointment or if you **cancel with less than 48 hours notice** from the beginning of your scheduled appointment, you will be billed the $125 fee. Missed appointments/late cancelation fees will **automatically be billed to your card** on file. ______ Initial

Telemental Health: I verify I am a GA resident and I will be physically located in GA during all therapy sessions. ______ Initial

Additional Service Fees: Completion of paperwork charges are $45/page for complex paperwork or reports and $20/page for simple paperwork. Copying charge for records is $2/page. ______ Initial

Termination of care: May be due to client's own desire to leave treatment or completion of client goals. I will contact you if you miss your scheduled appointment. If you have been out of service for over 6 months, your chart will be closed, and I will consider our therapeutic relationship terminated. ______ Initial

Smoking/Illegal & Illicit Drugs/Alcohol/Weapons

The possession, consumption, or distribution of drugs or alcohol during or before therapeutic session is strictly prohibited. No smoking during therapy sessions. In order to provide a safe environment, any objects intended to intimidate or cause bodily harm are prohibited. ______ Initial

Legal System

If I believe it would be necessary to subpoena my therapist to testify at a hearing or deposition, I will be responsible for her expert witness fees in the amount of $1500 for 4 hours (paid in advance) and $250 for each additional hour, including travel time and any interactions/conversations with the court system on your behalf. ______ Initial

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting me.
This authorization will remain in effect until therapy is terminated.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ HSA
Cardholder Name (as shown on card): ______________________________
Card Number: ______________________________
Expiration Date (mm/yy): ____________________ Security Code: _________
Cardholder ZIP Code (from credit card billing address): ____________________
Cardholder email: ______________________________

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I, ____, authorize Bree Winkler @ Private Counseling to:

- ____ Charge my credit card above for agreed therapy session purchases.
- ____ Charge my credit card above, **if** I **do not cancel my session at least 48 hours in advance** of my scheduled session **and** I agree to pay the full charge and card processing fee ($125) for the missed therapy session.
- ____ Save/Store my credit card information on file for all future transactions on my account until therapy is terminated and/or I choose another payment method.
- ____ Charge my credit card above for the $5/transaction credit card fee.

Client Name (printed): ____

Client Signature: ____ Date: ______________