Private Counseling

Bree Winkler, LPC, Ed.S., CAMS-II
5950 Crooked Creek Road
Suite150-C
Peachtree Corners, GA 30092
breewinklerLPC@yahoo.com
678-463-0884
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

LICENSE and CERIFICATIONS

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

QUALIFICATIONS

Bree Winkler is a Licensed Professional Counselor in the state of Georgia (#005623). In my private practice, I provide mental health services to clients. My specialization is in Depression, Anger Management, Anxiety, Adolescent concerns, and Relationship concerns.

I am qualified to work with individuals (adults and adolescents), couples, and families who are confronting various personal, emotional, social, and behavioral issues. I also conduct skill-based groups for clients with similar presenting issues. In addition to my areas of specialization listed above, I can also provide therapy for the following issues: coping skills, low self-esteem, academic underachievement, emotional disturbances, divorce, family conflict, entitlement, grief, peer relationships, self-harm, and life coaching (life skills and coping strategies). Therapy will focus on integrating Cognitive Behavioral Therapy with Psychodynamic Therapy to create a healthy therapeutic relationship between the client and the counselor.

NATURE OF COUNSELING

I provide a safe and comfortable therapeutic environment for individuals and families. 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.

If you choose therapy via **Telemental Health** options, please read and sign Online Therapy Informed Consent form, in addition to this document.

MISSION

I believe therapy should be a Holistic approach to healing the entire person. My mission is to maximize client satisfaction by providing quality therapy in a compassionate and respectful manner.

VISION

My vision is to provide mental health services to individuals and families in a comfortable environment. I will respect client's cultural, religious, and ethnic diversity. Therapy will focus on integrating Cognitive Behavioral Therapy with Psychodynamic Therapy to create a partnership between the client and the counselor.

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); no disclosure of such information without your written authorization, except in cases of medical emergency, by court order, or when otherwise allowed or dictated by law;
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. 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 any information revealed in session indicates physical, sexual, or emotional abuse, exploitation or neglect of children, elderly, or disabled persons.
2. I determine you are a danger to yourself or others.
3. I am ordered by the court to disclose information.
4. You (or parent or legal guardian) sign a written consent.

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.

CONTACT INFORMATION and APPOINTMENTS

As a client of Bree Winkler, you have direct access to me. Messages may be left on my confidential voicemail anytime, at 678-463-0884; I will return your call within 24 hours. You may also send me an email at breewinklerlpc@yahoo.com or text me for questions, concerns, or appointments.

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.

Your appointment time has been reserved for you and you are encouraged to arrive on time. If you are late, you will still be responsible for the entire fee and will be seen for the remaining portion of your session. I will not be able to extend your time as others with scheduled times after you are affected.

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 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 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.

INFORMED CONSENT for ONLINE THERAPY

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 Skype, FaceTime, 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
- Easy to schedule
- Prepay for sessions online
- Quality of psychotherapy is the same as face-to-face sessions

DISADVANTAGES of TELEMENTAL HEALTH THERAPY

- Limitations of confidentiality via technology
- 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

FORMS to COMPLETE

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

- Adult **or** Child Information Form
- Informed Consent (below)
- Telemental Health Consent (below)
- Fee Policy (below)
- Insurance Information (below, if applicable)
- Release of Information for doctor, psychiatrist, or school (if applicable)
- 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 the undersigned 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 provider's license, certification, and training. 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

Telemental Health Consent – All electronic communication

Individuals occasionally will have a crisis and want to use text or email to contact me. 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. Typically, an individual will contact me via text/email to reschedule an appointment or to ask if we can talk.

___ 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 that by choosing **Skype/FaceTime** 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 (via **Skype/FaceTime)** for therapy sessions, I understand that technology problems may arise, including Internet connection problems, audio or picture difficulties, and other non-therapy technology setbacks. By checking, client will work with Bree to determine the appropriate alternatives to sessions (such as rescheduling, utilizing phone for that session, or scheduling an in-person session).

___ If choosing Online Therapy (via **Skype/FaceTime)** for therapy sessions, I verify I am a GA resident.
OR
___ If choosing Online Therapy (via **Skype/FaceTime)** for therapy sessions, I verify I am **not** a GA resident; however, **I understand that I must follow the rules and ethics for online therapy in the state of Georgia**.

My Skype ID is: _____

Policy Agreement

FINANCIAL TERMS AND FEES

My fee for service is **$95 for each 50-minute therapy session**. The **initial assessment fee is $130 for a 60-minute assessment**. I accept cash, check, or credit card for payment. _____ Initial
** Credit card processing fee is $3/transaction. (complete p.7) _____ Initial
** If paying by check or cash, please have payment ready prior to session. _____ Initial

Insurance (if applicable)

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 and/or b) your insurance does not cover. **Services not covered by your insurance will automatically be billed to your credit card**. **(Complete p.7)** _____ Initial

Payment Authorization for Insurance

I authorize Blue Cross Blue Shield 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**_____

Insurance Information: Insurance Company _____
Member #: _____Group #: _____
Date of Birth: _____ Phone # for Provider/Claims (on back of card): _____

**** Provide a copy of the front and back of your insurance card. ****

Telemental Health: Convenient therapy sessions offered via Skype, FaceTime, or telephone session. 30-minute session for $50 or 50-minute session for $95.
Sessions must be pre-paid via PayPal at www.PrivateCounselingGA.com _____ Initial

Cancellation/Missed Appointment Fees: Scheduled appointment times are reserved especially for you. If an appointment is missed or it is cancelled with less than 24 hours notice from the beginning of your scheduled appointment, you will be billed a fee. Your missed appointment fee is equal to your session fee ($95). **Missed appointments will automatically be billed to your credit card (complete p.7).** _____ Initial

Additional Service Fees: Paperwork charges are $45/page for complex paperwork or reports and $20/page for simple paperwork. Copying charge for records is $50. Court appearance charges start at $500 and increase depending on time spent in court and client scheduling time lost. Please discuss cost of these and other services with me. _____ 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
The possession, consumption, or distribution of illegal/illicit drugs or alcohol during or before therapeutic session is strictly prohibited. No smoking during therapy sessions. _____ Initial

Weapons
It is my intent to provide a safe environment that contributes to the treatment process. Therefore, guns, knives, and any other object intended to intimidate or cause bodily harm are prohibited. _____ 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
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ Security Code: _____
Cardholder ZIP Code (from credit card billing address): _____
Cardholder email: _____

I, _____, authorize Bree Winkler @ Private LLC to:

- o ____ Charge my credit card above for agreed therapy session purchases.
- o ____ Charge my credit card above, **if** I do not cancel my session 24 hours in advance and I understand and agree to the full charge for the missed therapy session will be applied to this credit card.
- o ____ I understand my credit card information will be saved on file for all future transactions on my account until therapy is terminated and/or I choose another payment method.
- o ____ I understand and agree to pay the $3/transaction credit card fee.

Client Name (printed): _____

Client Signature: _____ Date: _____