



## PERSONAL ENRICHMENT SERVICES, INC.

### Adult Consent & Authorization to Treatment

Office Location:

2801 Buford Highway  
Druid Chase Ste. 503  
Atlanta, GA 30329

For Information Contact:

(770) 928-5130  
www.personalenrichmentservices.com  
pescounseling@bellsouth.net

The following is a consent and authorization for Personal Enrichment Services Inc. to provide psychotherapy services to you (hereinafter “Client”) and to obtain payment. Please be aware you may revoke this consent and authorization at any time by requesting cancellation. However, Personal Enrichment Services Inc. must refuse to provide psychotherapy services to you without consent and authorization. If you consent to this authorization then please provide the necessary information and your signature with today’s date as indicated below. Your file will be considered closed if we have not had a session in 30 days. You would need to let us know you wished to reopen your file to resume treatment.

**Welcome!** I am pleased you have selected Personal Enrichment Services, Inc. This document is designed to inform you about the educational background, theoretical orientation, and work experience of your therapist, as well as to insure that you understand our professional relationship. Although providing this document is part of an ethical obligation to our profession, more importantly, this document is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that our relationship is a collaborative one, and we welcome any questions, comments, and suggestions regarding your course of therapy at any time.

**Background & Experience:** Our counselors hold Masters Degrees. They are licensed in the state of Georgia and hold additional certifications in their specialty areas. They have experience counseling couples, families, adolescents, adults, and children. They have worked extensively with substance abuse, couples therapy, and young adults especially.

**Theoretical Orientation:** We focus on using the approach that is most appropriate for the client and their particular issue. However, we do prefer the following theoretical approaches for conceptualizing many issues: systems theory, cognitive behavioral therapy, rational emotive therapy, 12-step and strengths based counseling.

**Records & Confidentiality:** All of our communications become part of the clinical record of treatment and is referred to as Protected Health Information (PHI). Your record is accessible to you upon request. I will keep confidential anything you say to me, with the following exceptions: (a) Use or disclosure to provide treatment, to obtain payment for services provided, and for other professional activities (known as "health care operations"); (b) Use or disclosure for purposes of my direction and clinical supervision; (c) Use or disclosure of anonymous clinical information for purposes of research; (d) You direct me to tell someone else and you sign a “Release of Information” form; (e) I determine that you are in imminent danger of harming yourself or others; (f) You report information to me about abuse of a child/adolescent, an elderly person, or a disabled individual, and you decide not to report this information to the proper authorities (e.g., DFACS) as mandated by law and the ethics of my profession; or (g) I am court ordered to disclose information. In the latter case, my license does provide me with “privileged communication,” meaning that a court order can also be appealed if deemed harmful to you. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say to me confidential.

Revised 4/15/2010

If you are participating in group, family, or couples psychotherapy then please be aware that I cannot guarantee all participants will maintain your confidentiality. By signing this document you are indicating that *you* will agree to uphold any information learned during a therapy session in the utmost confidence. Likewise, please be aware that I have required each participant in psychotherapy with me to also make this agreement. However, please be aware that in couple's counseling, I do not agree to maintain confidentiality between partners.

**Professional Relationship:** Although our sessions may be very intimate emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you have with me. You will be best served if our relationship remains strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your therapy experience. However, it is important for you to remember that you are experiencing me only in my professional role.

There are important differences between therapy and friendship. As your therapist I cannot be your social friend. I will attempt to facilitate you in your process of solving problems by making use of techniques that are based on tested theories and methods of change. I will offer you choices and help you to decide for yourself what is best for you.

You should also know that if I see you out in public, I will keep your identity secret and I will not address you unless you speak to me first. I must as well decline any invitation to attend gatherings with your family and friends. Finally, when your therapy with me is completed, you should know that I will not be able to be a social friend. My duty is to care for you and my other clients in the professional role of a psychotherapist.

**Emergency:** If you are having a medical emergency then call 911 or seek out services at your local hospital emergency room. If you are having a psychiatric emergency then you can call Ridgeview Institute at 770-434-4567. Please understand that I am not available at all times. If you are in need of immediate assistance then do not wait for me to call you back. Personal Enrichment Services, Inc. is an outpatient facility and is designed to accommodate individuals that are reasonably safe and resourceful. If at any time this does not feel like sufficient support then please inform me and we can discuss additional resources or find you a therapist or clinic with 24-hour availability.

**Non-Emergency:** You may call and leave a message in my confidential voice mailbox at 770-928-5130, along with a telephone number where you can be reached, and I will call you back when I am available. I usually return calls within less than 48 hours (please see "Fees for Services Provided" section in this document). If I am going to be unavailable for longer than 48 hours then I will leave detailed instructions on my voice mailbox message.

**Scheduling Appointments:** Appointments may be scheduled using my confidential voice mailbox at 770-928-5130. Appointments may also be scheduled using email, however, please be aware that I do not provide any therapy services via the internet/email. I also cannot guarantee confidentiality for communications sent via email. If you need to get in touch with me quickly, please note that I tend to check my voice mailbox more frequently than my email account. Please do not cancel appointments via email. My email address is pescounseling@bellsouth.net.

**Cancellation of Appointments:** In the event that you will not be able to keep an appointment you must notify me at least 24 hours in advance of the scheduled session. If such advance notice is not received then you will be responsible for full payment of the session (please see "Fees for Services Provided" section in this document). For example, you would need to notify me of a cancellation by 10:00 a.m. on Tuesday, if you have an appointment scheduled with me at 10:00 a.m. on Wednesday. Please notify me about cancellations via telephone at 770-928-5130 or call directly on my cell phone in order to insure that I receive your message as soon as possible. Please also be aware that EAP and insurance companies do not reimburse for missed sessions. I am committed to being available at our scheduled appointments; however, in the rare instance that I need to cancel your appointment with less than 24 hours notice then I will allow you one such cancellation in the future.

## Fees for Services Provided:

My services will be provided to you at the following rates unless otherwise negotiated:

<b>Forensic Evaluations</b>			<b>Therapy Services</b>		
<u>Alcohol &amp; Drug Evaluation</u>	90 minute session with report:	\$200	<u>Intake/Diagnostic Assessment</u>	CPT Code 90801 45-50 min.	\$130
<u>Anger Management Evaluation</u>	90 min. session with report:	\$200	<u>Individual Outpatient Psychotherapy</u>	CPT Code 90804 20-25 min.	\$60
<u>DUI Clinical Evaluation</u>	90 min. session with forms:	\$200		CPT Code 90806 45-50 min.	\$110
<b>Telephone calls (confidential)</b>				CPT Code 90808 75-80 min.	\$130
Calls exceeding 5 minutes	“Intermediate” CPT Code 99372	\$2.00 per min.	<u>Family Psychotherapy</u>	CPT Code 90846 45-50 min.	\$120
Multiple calls during same week (Sun. - Sat.)	“Extended” – CPT Code 99373	\$2.00 per min. entire call	<u>Two Family Members or Couple Psychotherapy</u>	CPT Code 90847 45-50 min.	\$120
<b>Written Correspondence</b>			<u>Group Psychotherapy</u>	CPT Code 90853 45-50 min.	\$60
Reports in connection with a client’s evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others:		Charges Vary  Request a quote for your specific needs	<u>Career Check-up (Initial Consult, Assessment &amp; Planning)</u>		\$350
Returned Checks		\$30.00	<u>Career Assessment</u>		150

**Website Information:** If you need a map or directions to Personal Enrichment Services, Inc., go to [www.personalenrichmentservices.com](http://www.personalenrichmentservices.com). Or let me know and I will send/email/verbally give you directions. At the website, you will find current information regarding my schedule and available services such as assessments, online payments, etc.

**Concerns:** If at any time and for any reason you are dissatisfied with my services then please contact Dan Martin.

**Proof of Identity/Emancipation:** You may need to present picture identification to substantiate name and person (e.g., valid driver’s license). If treatment has been mandated by another agency, you may need to provide information/documentation. If you are an emancipated minor, you may need to provide substantiating documentation.

**Payment for Services Provided:** The fee for each session will be due at the conclusion of the session unless otherwise negotiated (please see “Fees for Services Provided” section in this document). Cash, money orders, cashier’s checks or personal checks made payable to “Personal Enrichment Services, Inc.” are acceptable for payment. You may also make payments using your Visa, Master Card, Discover or American Express in the office or via the web site at [www.personalenrichmentservices.com](http://www.personalenrichmentservices.com). It is your responsibility to make payment for services. We will be glad to file with your insurance plan for possible reimbursement. If insurance coverage has been arranged, payment of any applicable copayment or deductible is due at the time services are rendered. If your insurance plan denies the claims you will be responsible for the fees for services. Payment remains your responsibility.

We ask to keep a signature and credit card information on file for every client. In the event that you cannot or do not pay whatever fees are your responsibility at the time of your visit (please see “Fees for Services Provided” section in this document), we will submit the charge to your credit card. We ask you to sign below indicating your agreement and consent to this procedure. Your card will be charged only if you do not pay at the time of your visit, or if there are outstanding charges for missed appointments or late cancellations.

Name On Card	Card Number		Security Code (3-4 Digits)
Signature of Card Holder	Date	Expiration Date	Card Type

By your signature below you are indicating that you, Client, have read and understood this consent and authorization, and/or that any questions you have had about this document have been answered to your satisfaction. If you have any further questions then please feel free to ask at any time. This consent and authorization is effective beginning on the date indicated below.

**Client’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_