Joshua M. Noblitt
CREATIVE APPROACHES TO HEALING

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NEW PATIENT TREATMENT CONSENT

A personal note on my philosophy:

I'm thankful for you and glad to be on this journey with you! Therapy is an alliance that increases human understanding, improves relationships, and brings about needed change. Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by the client and the therapist. This frame helps create the safety to make the necessary changes that will improve your life. As a client in psychotherapy, you have certain rights; there are also certain limitations to those rights of which you should be aware. As a therapist, I have corresponding responsibilities to you.

Therapy works best if you put consistent effort toward self-reflection and change. It is not magic, nor is it simply about giving advice. Many people's emotional struggles come from certain beliefs that prevent them from functioning at their best, from difficulties managing emotions, such as anxiety, depression, shame, or anger; from traumatic experiences; and from particular relational patterns that prevent good and stable relationships. Therapy will help you focus on not only what you think, feel, and do, but perhaps why you have these patterns, and what you can do to change them.

Therapy should not be a mystery. You have the right to ask questions about anything that happens in therapy. I am willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training and experience for working with your concerns, and can request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time.

You agree to participate actively in the therapeutic process by (1) collaboratively working on realistic and concrete goals, (2) working on your issues between sessions, and (3) being honest with your therapist. Remember, your therapy is only as good as the effort you put in to it!

Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried to avoid may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me is a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. I will inform you beforehand of any potential risks and benefits of any special treatment techniques, so that you may decide for yourself if it might be right for you. If at any time you feel an intervention is not helping, please let me know immediately.

And Now The Fine Print…

Please read the policies on the pages that follow and sign indicating your consent to treatment and agreement with the practice policies.

Please initial that you have read this page: _____

Professional Credentials and Licensing Regulations:

I am a Licensed Marriage and Family Therapist (#001177) in the State of Georgia. These credentials are regulated by the Georgia Composite Board of Professional Counselors, Marriage and Family Therapists and Clinical Social Workers. I also am certified as a Sex Therapist by the American Association of Sexuality Educators, Counselors, and Therapists.

Information about the State of Georgia regulations governing counselors, clinical social workers, marriage and family therapists and psychologists can be found with the Secretary of State website. Ethical complaints can be voiced with me and/or with these governing organizations.

Confidentiality:

The contents of therapy, intake, or assessment sessions are considered confidential. Both verbal and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian. It is my policy to adhere to the standard rule that any information about a patient will not be released without a signed release of information. Noted exceptions are listed below:

Duty to warn and protect - When a patient discloses intention or a plan to harm another person, I am required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan of suicide, I am required to notify legal authorities and make reasonable attempts to notify family members.

Abuse of children and vulnerable adults - If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service and/or legal authorities.

In the event of a patient's death - The spouse or parent of the patient has a right to access their spouse's or child's medical/health records.

Professional misconduct – I must report misconduct by other healthcare professionals. In cases in which a professional or legal disciplinary meeting is being held regarding a health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court orders - I am required to release records of patients when a court order has been placed.

Third party payers - Insurance companies and other third party payers are given information that they request regarding services to patients. Information may include types of services, dates/times, of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Professional consultation – I may disclose information in consultation with other professionals in order to provide the best possible treatment. In such case the name of the patient or any identifying information is not disclosed. Only sufficient clinical information about the patient is discussed to allow adequate consultation about treatment process and/or ethical considerations. I meet regularly with a consultation group to comply with the industry standard of care of seeking consultation.

Other provisions - In the event that I need to contact you for the purpose of scheduling, cancellations, or reminders or to give/receive other information, efforts will be made to preserve the confidentiality of the counseling relationship by following the guidelines you have requested on your New Patient Record form.

Interaction With the Legal System:

By signing this agreement, you agree that you will not involve or engage your therapist in any legal issues or litigation in which you are a party to at any time either during your counseling or after counseling terminates. This would include 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 you execute a proper release, your therapist will provide you with a copy of your record, and you will be responsible for charges in producing that record. If you believe it necessary to subpoena your therapist to testify at a deposition or a hearing, you will be responsible for his expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time your therapist spends over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. You understand that if you subpoena your therapist, he may elect not to speak with your attorney, and a subpoena may result in your therapist withdrawing as your counselor.

INFORMATION, AUTHORIZATION & CONSENT TO TELEMENTAL HEALTH

This portion of the treatment consent document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to 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, a 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)

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 developed several policies and protective measures to assure your PHI remains confidential. These are discussed in the following section.

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 who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided that phone number to my office, we may contact you on this line, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please make your concerns known to me. Telephone conversations (other than just setting up appointments) are billed at your therapist's hourly rate.

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. I may also use a cell phone to contact you, typically only for purposes of setting up an appointment if needed. If this is a concern for you, please let me know, and you I will be glad to discuss other options. Telephone conversations (other than just setting up appointments) are billed at the prorated hourly rate.

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. However, many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that therapists are required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:
Email is not a secure means of communication and may compromise your confidentiality. However, many people prefer to email because it is a quick way to convey information. It is my policy to utilize this means of communication strictly for intake information, billing, and appointments. I strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).
Email is billed at the prorated hourly rate for the time spent reading and responding. If you are in a crisis, please do not communicate with me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures." Finally, you

also need to know that therapists are required to keep a copy or summary of all email 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 any of my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

However, Joshua M. Noblitt, LLC Psychotherapy has a **professional** Facebook page. You are welcome to "follow" this **professional** page where I post psychology information/counseling information/therapeutic content.

However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Joshua M. Noblitt, LLC. Please refrain from contacting me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not monitor them closely. We would not want to miss an important message from you.

Google, Bing, etc.:

It is my policy not to search for clients on Google, Bing or any other 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 or please email this material and remember that your therapist's hourly charge applies to the time spent reading and responding to email. Once again, if you are in a crisis, please do not communicate this via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Video Conferencing (VC):

Video Conferencing is an option for therapy to be conducted via remote sessions with you over the internet where we may speak to one another as well as see one another on a screen. I utilize Doxy.me or another secure platform. These VC platforms are encrypted to the federal standard, HIPAA compatible, and have signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.me or other platform is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely and how to use the technology. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure that we get started promptly. Additionally, you are responsible for initiating the connection with your therapist at the time of your appointment. We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Faxing Medical Records:

If you authorize me (in writing) via a "Release of Information" form to send your medical records or any form of PHI to another entity for any reason, I may need to fax that information to the authorized entity. It is my responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of the fax machine. However, the fax machine that I use is kept behind two locks in our office. And, when the fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device impossible.

Recommendations to Websites or Applications (Apps):

During your 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 and/or 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 not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Certain Credit Card Transactions:

I use a company that processes your credit card information securely such as Therapy Partner, Square, or PayPal. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card at our facility, 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 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 Joshua M. Noblitt, LLC.

Please initial that you have read this page: _____

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.

Communication Response Time

I'm required to make sure that you're aware that I'm located in the city of Atlanta and we abide by Eastern Standard Time. My practice is an outpatient facility, and is set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please let me know, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I make every attempt to return phone calls, texts, and emails within 24 hours. However, I do not return any form of communication on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from your therapist, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24-hour crisis hotline in your area
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice

Emergency Procedures Specific to TeleMental Health Services

There are additional procedures specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that I cannot address remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____ Phone: _____
- You agree to inform your therapist of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform your therapist of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:
  Hospital: _____ Phone: _____

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and that I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within ten minutes, please call me. If we are on a phone session and you get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Structure and Cost of Sessions

At Joshua M. Noblitt, LLC Psychotherapy we offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, I may provide phone, or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. we will discuss what is best for you.

Please initial that you have read this page: _____

The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions. I agree to provide face-to-face and TeleMental Health therapy for the fee of $175.00 per 45-50 minute session. If you and I negotiate a different length session, the fee will be adjusted accordingly. Non-scheduling related texting and emails are billed at my prorated hourly rate for the time I spend reading and responding.

You may pay for your sessions via cash, check, or credit card. There is a cash/check discount to $170.00. If you wish to use your credit card, I use Square to process charges and accept Visa, MasterCard, Discover, and American Express. You will need to sign the Credit Card Authorization Form, which indicates that we may charge your card without you being physically present. Your credit card will be charged after each face-to-face or TeleMental Health interaction. **This includes any therapeutic interaction other than setting up appointments. You will also be charged for a missed session per the cancellation policies described in this document.** I have a limited number of spaces in my practice for clients who need to negotiate a reduced fee. If this applies to you and if I have space available at the time, we will discuss and agree on a fee and sign a reduced fee contract.

All clients are requested to pay at the time of service unless other arrangements have been made. I do not accept insurance assignment or file claims, but will provide you with a statement to submit if you desire. If you choose to do so, they should reimburse you directly. If they send me the check, I will void and return it with instructions to issue it to you. **Once you file with your insurance carrier, I have NO CONTROL over how your personal health information is handled**. The carrier may request data about your therapy such as treatment plan, summary of treatment, likely outcome, etc. At minimum, they will have your diagnosis in order to pay. Regardless of your decision about filing claims, you are responsible for payment of your therapy fee, or if you are a minor, your guardian is responsible for payment. There is no guarantee that they will reimburse for service fees you have paid.

Insurance companies have many rules and requirements specific to certain benefit plans. Currently, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for TeleMental Health services. As stated above, 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. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

If you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, your therapist might not see a tear in your eye. Or, if audio quality is lacking, he or she might not hear the crack in your voice that he or she could have easily picked up if you were in our office. There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and strongly encourage you to let me know if something I said or did upset you. I invite you to keep the communication with your therapist open at all times to reduce any possible harm.

Face-to Face Requirement

If we agree that TeleMental Health services are the **primary** way that we will conduct your sessions, **I require one face-to-face meeting at the onset of treatment.** I prefer for this initial meeting to take place in my office.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing me to use for your treatment or administrative purposes. You and I will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be using that technology unless otherwise negotiated by you.

Please initial that you have read this page: _____

- € Texting
- € Email
- € Video Conferencing
- € Website Portal
- € Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

In the Event of My Death or Incapacitation:

In the event that I should die or become incapacitated, you will be contacted by a colleague of mine if you have a pending appointment. You will be contacted with regard to continuation of services, or referral assistance, along with a debrief session to assist you with the loss. Your contact information only will be made available and accessible to the person who will contact you in the event that it is necessary.

Rights & Responsibilities:

You have the right to be treated with respect, you have the right to be informed about your treatment, and you have the right to be informed about your confidentiality and to be informed about the limitations of confidentiality. You have the right to terminate psychotherapy at any time without penalty. You have the right to ask questions and voice concerns. You have the responsibility to attend and participate in therapy. Participation includes formation of goals and communicating with me regarding your concerns. You have the responsibility to pay for sessions and to pay the late cancellation or missed appointment fee if you no-show or cancel with less than 24-hour notice.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing us to utilize the TeleMental Health methods discussed.

_____ _____
Client Name (Please Print) **Date**

_____
Client Signature

If Applicable:

_____ _____
Parent's or Legal Guardian's Name (Please Print) **Date**

_____
Parent's or Legal Guardian's Signature

Your therapist's signature below indicates that he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Therapist's Signature **Date**

Please initial that you have read this page: _____