Jon Garlick, LPC Disclosure and Consent Form

Thank you for deciding to seek counseling with Jon Garlick, LPC. The following information will help you understand many of the details about your therapy. A primary commitment of mine is to provide quality, time-effective treatment to individuals, couples and families regardless of age, sex, race, or religious affiliation. I am committed to the client's rights of information regarding policy, non-discrimination, confidentiality, consent and competent service. Therefore, my various policies are listed below for your information. Please read through these, ask any questions you may have and sign on the last page. Thank you.

THERAPIST'S NAME AND CREDENTIALS: Jon Garlick, MS, Ed.S. LPC, NCC

You are entitled to know that I have received my Master's Degree (MS) and an Education Specialist Degree (Ed.S) in Community Agency Counseling from Jacksonville State University. I am also a Licensed Professional Counselor (Lic #2304) and a Nationally Certified Counselor as well as a Clinically Certified Juvenile Treatment Specialist. I have been trained in a variety of specific methods of treatments and will determine the approaches and techniques that might be most effective for your particular needs. Psychotherapy is not like a visit to a medical doctor, but rather it requires a very active effort on your part as the client. In order for therapy to be most successful, you will need to work on issues discussed in therapy, both inside our therapy sessions and outside our therapy sessions. Psychotherapy can have both benefits and risks. Given that therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as fear, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have numerous benefits. Such benefits may include a greater ability to function in your roles at home, work, or school, and that you may be able to better cope with or handle your family and/or other social relationships, thus experiencing a greater satisfaction from these relationships. Through psychotherapy, you may also come to better understand your personal goals and values, which may lead you to greater maturity and growth as a person. But there are no guarantees as to what you will experience.

MEETINGS: Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work together will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions regarding whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. If you choose to begin psychotherapy, we will usually schedule a 50-minute session at a mutually agreed upon time. Typically, my clinical hour is 50 minutes long. Each session is considered one clinical hour, unless otherwise decided upon. The frequency of your sessions may vary according to your needs. The length of treatment varies widely and is often very difficult to predict ahead of time. However, we can discuss the length of treatment and I will attempt to give you my best estimate as to the expected duration of your treatment.

With your written authorization, I would be happy to discuss your treatment with previous therapists, however, I do not engage in concurrent therapy with another counselor or therapist. Clients will be referred to seek treatment elsewhere if the content or required mode of the therapy is outside of my area of expertise, if the client is unable or unwilling to contract for safety, or if a balance is owed. You have the right to avoid dual relationships with your therapist. The relationship with your therapist should remain strictly professional.

Consistent with my established moral and ethical position, Alabama law requires that any individual seeking any services must be informed that sexual contact between client/patient and therapist is not a part of any recognized therapy. Sexual intimacy between client/patient and therapist is never appropriate, is illegal, and should be reported.

CONTACT and COMMUNICATION: Due to the nature of my work and my schedule, I am often not immediately available by telephone. When I am unavailable by telephone, my telephone is answered by a voicemail system which immediately notifies me of every message left. I will make an effort to return your call on the same day in which your message was left, with the exception of messages left during evenings, weekends, and holidays. I do not return calls to pagers. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, the nearest emergency room, your local mental health network or simply dial 911. While you may contact me via email, you should know that email is NOT a confidential means of communication and that the confidentiality of information exchanged via email cannot be guaranteed.

EMERGENCY PROCEDURES: If you have a mental health emergency, please call 911 or your local mental health network.

INSURANCE : I am not contracted (in network, preferred provider) with any insurer. I will provide you with a receipt for therapy services at your appointment, upon request, that may be used to submit for reimbursements if allowed by your insurance provider. Please note that I do not complete any insurance paperwork.

CANCELLATIONS: At times, it may be necessary for you to cancel your appointment. To help me to be most efficient and responsible with my time, I require that any change or cancellation be made at least 24 hours in advance. If you cancel your appointment outside of 24 hours, there will be no charge for your scheduled session. Any changed, canceled, or missed appointment with less than 24 hours of notice will be charged the full session fee.

CONFIDENTIALITY: The law protects the communications between a client and a psychotherapist. In most situations, I can only release information regarding your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require that you only provide written, advance consent. Your signature on this disclosure form provides consent for those activities as follows: I may occasionally find it helpful to consult with other health and mental health professionals about a client. During the consultation, I make every effort to avoid revealing the identity of my client. The other professionals with which I consult are also legally bound to keep the information discussed confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record. Unless you grant me permission to do so in writing, therapists and the office personnel will neither inform anyone that you are receiving therapy, nor will they disclose the content of any session. There are some situations where I am permitted or required to disclose information without either your consent or Authorization: • If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychotherapist/client privilege law. I cannot provide information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. • If a government agency is requesting the information for health oversight activities, I am required to provide it for that agency. • If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client to defend myself. • If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. • If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect or if I have observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect, the law requires that I file a report with the

appropriate governmental agency. Once such report is filed, I may be required to provide additional information. • If I have reasonable cause to believe that an at-risk adult has been or is at imminent risk of being mistreated, self-neglected, or financially exploited, the law requires that I file a report with the appropriate governmental agency. Once such report is filed, I may be required to provide additional information. • If a client communicates a serious threat of imminent physical violence against a specific person or persons, I must make a timely effort to notify such person or persons; and/or notify an appropriate law enforcement agency; and/or take other appropriate action, including seeking hospitalization of the client. If any such situation arises, I will make every effort to fully discuss it with you, the client, before taking any action and I will limit my disclosure to only that information which is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, you may need to obtain formal legal advice. By signing this document, you are agreeing that you understand that if you elect to use your health insurance plan to assist in the payment of treatment then that insurance carrier and the National Information Center will have access to my diagnosis code and other pertinent data needed for the claims process.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I have been informed of and have read all of the preceding information, understand my rights as a client, and I agree to all information stated above. I authorize the treatment of the person named below and agree to pay all fees as stated above.

(initial) _____

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Signature of Client Signature or Legal Guardian Date

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Signature of Jonathan C. Garlick Date