Yori Aiyeola- Scott, MA, LPC

Therapy Works Counseling
Services LLC Stone
Mountain, GA 30087
470-863-8536

Information for Clients and Informed Consent

Please read all the way through very thoroughly and note any questions you may have in the margins. We will review the policies and contents herein at our first session and I can answer your questions at that time. Please be sure to fill out the last page prior to coming into the office or arrive 15 minutes early to do so. When you arrive please have a seat in our waiting area and I will come out and greet you at your time of appointment. Thank you!

The therapist

I am a therapist at Therapy Works Counseling Services, LLC and I provide counseling services for children, families, parents, and individual adults. In addition I work as a School Counselor at a local independent school.

I have a masters degree in professional counseling and an undergraduate degree in communications and psychology. I worked as a primary and early childhood counselor for over 10 years. I have worked with clients in a residential treatment facility for drug and alcohol addiction and have a particular interest in helping women through life transitions. I am a Certified Counselor and a School Counselor.

I participate in continuing education courses, seminars and professional conferences ongoing in order to stay current and am always expanding on my knowledge-base and methodologies in order to best serve the needs of my clients.

I am an active member of the American Counselor Association, the Licensed Professional Counselors Association of Georgia, and the American School Counselors Association.

Counseling

My approach to counseling is eclectic in nature drawing from many different theories. In particular I believe that children and adults are seeking to belong and feel significant in their lives. I work to help clients develop a perception of power and influence so that they can then learn to accept the power they have to create positive change. They gain an understanding of their personal emotions and behaviors by hearing feedback in a safe accepting environment. Through the problem solving process they can learn alternative ways to express and deal with their thoughts and feelings. Children often don't have the language to express their feelings and can benefit greatly from play therapy where they are free from judgment and safe to express their deepest emotions.

Effective counseling experiences require active commitment and participation on the part of the client. Together we will set goals and determine indicators as to how we will know when those goals have been met and will frequently revisit these goals, evaluating where we are in the process of making progress so that each client knows how we are doing as a partnership as we go.

If you wish at any time to stop counseling services with me, I ask that you allow one final session in order for us to have appropriate closure allowing me an opportunity to assist you in finding support beyond our counseling relationship.

Benefits and Risks of Counseling

Benefits of counseling have been shown in many well-researched studies. However, change and the processes involved in creating positive change can at times be difficult and unsettling. In some cases, especially with children, symptoms worsen before improving. Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed.

Confidentiality

It is a client's legal right that our sessions and my records about you are kept private. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are exceptions as follows:

1. When the client signs a release of information requesting that the therapist divulge information.
2. When a client is believed to be a danger to self or others.
3. When a minor is suspected of experiencing physical or sexual abuse, your therapist is legally and ethically bound to make a report to the Department of Family and Children's Services.
4. When disclosure is required by a valid court order.
5. The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Additionally, I am happy to file or provide you with paperwork to file with your insurance company; however, insurance companies require a diagnosis for reimbursement. Confidentiality cannot be guaranteed by your therapist once information is given to insurance companies.

My professional supervision and/or consultation with other licensed therapists are times where I share information about my cases for the purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality.

If you should choose to communicate with me via email, confidentiality cannot be guaranteed and information may be accessible to others. We can communicate confidentially through hushmail. Clients may choose to set up a free hushmail account at www.hushmail.com. This system encrypts the content of your email and mine and protects your private information. Please indicate your preference by checking Yes for regular email or that you plan to sign up for hush mail and signing here:

Yes, I understand my email is a limit to confidentiality and I do authorize you to communicate with me via email:
_____(signature)

Please provide the email address where you authorize me to send you emails:

_____I plan to set up a hushmail account to communicate with my therapist. I will provide the therapist with this email address once the account is established and my therapist will provide me with her hushmail address.

In the case of my death or major medical incapacitation, all of my records will be accessed by Darryl Brooks, LPC, CPCS, NCC.

More on confidentiality:

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

In **working with couples and families**, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I ***will not be a "secret keeper" nor will I facilitate secret keeping..*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it to be brought up in the next session together so we can work through it.

Scheduling and Cancellations

When you schedule an appointment with me, we are making a contract in advance for time in my preparation for your session and time in session. I schedule appointments in advance (no walk ins) and **I do require 24 hours notice of cancellation of any appointment**.

If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, there will be a $100.00 charge.

On the most rare occasion there is what I consider to be a true emergency which is a death of someone close to you or sudden and extreme illness requiring a documented visit to a medical facility, I will waive the charge.

Missed appointments will be billed at $50.00 in any other

case. Fees, Payment, Insurance…

My fee is $100 per session. I work on a 50 minute session schedule in order to allow minutes between sessions. The session fee is not only for our 50 minutes together in person as each session fee covers periodic and brief communication between sessions by email and phone, all the preparation I do prior to each of your sessions and all of the post-session work that I do for your ongoing progress in counseling. I do require payment of fees be made at the beginning of each session so business can be out of the way in order to sink into the issues the client needs during the session. I will be happy to provide paperwork for you to file with your insurance company for out of network reimbursement.

After Hour Support and Emergencies…

Therapy Works Counseling Services, LLC is not an emergency services agency. I do not provide emergency services. You may call me during business hours (Tuesday through Friday 9:00am to 7:30 pm) on my mobile number 470-863-8536 and leave me a confidential voicemail including your phone number even if you know that I have it along with a brief message. I will call you back when I have finished all sessions and business with other clients or between sessions if possible and if not possible the same day that you leave the message, as soon as I can the next day. When I am away from the office for extended time, my message will reflect when I will be back. **If you have a life threatening emergency you should call 911 or go to the hospital of your choice.** Only contact me in an emergency after you have obtained emergency assistance from 911 or your choice of medical support.

Other After hour Mental Health Resources (not to be substituted for calling 911 with emergency):

- Ridgeview Institute at 770-242-4567 or Peachford Hospital at 770-455-3200 • Cobb County Mental Health Crisis Line 770-422-0202
- Lakeview Behavioral Health at 678-713-2600

Divorce and Custody

I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

1. I require a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session BEFORE I am able to meet your child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the

child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

2. I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

3. I ask all my clients to waive the right to subpoena me to court. This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relations relationship with you and/or your child(ren). My appearance in court often damages my therapist client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving the right to have me subpoenaed and agreeing not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if you prefer.

4. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of $250/hour of my professional time. Any of my time dedicated to any court- mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the courthouse in addition to time on the stand as well as any travel time will be billed at $250 per hour.

I understand these policies and hereby waive any and all rights to subpoena Yori Aiyeola-Scott, LPC, and the clinical record on any current or future legal proceedings.

Printed Name _____

Signature _____

Date _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law to do this and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems. I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for

services, or for other business activities, which are called in the law "healthcare operations". After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat you or your child. Of course, I will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

1) When there is a serious threat to you or your child's health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2) Some lawsuits and legal or court proceedings.
3) If a law enforcement official legally requires me to do so.
4) For workers compensation and similar benefit programs.

There are some other situations like these that do not happen very often. They are described in the long version of NPP.

Client Records

You should be aware that, pursuant to HIPAA, I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. It could include information about your reasons for seeking therapy, a description of the ways it is sent to anyone, including reports to your insurance carrier. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of $25 charged for preparing the record for release.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

Signature indicating I have read and received the Notice of Privacy Policies:

_____ _____

Printed Name Signature Date

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number:

Georgia Composite Board of Professional Counselors,
Social Workers, and Marriage and Family Therapists
237 Coliseum Drive
Macon, GA 31217-3858
(478) 207-2440

Crisis Response Plan

I require each and every one of my clients to fill out the following Crisis Response Plan as standing plan and agreement just to be sure that in the case a Crisis should arise that lends to feelings or thoughts of self harm or harm to another you will be prepared to know how to respond even if you believe this will never apply to you. I realize it may seem strange. I am asking for you to fill this out and sign this, but I have found in my experience it is always better for me to be assured each and every one of my clients prepared in case of a crisis. There is a Crisis Response Plan for adult clients and a Safety Promise and Plan for child clients.

Therapy Works Counseling
Services, LLC ADULT CLIENT
CRISIS
RESPONSE PLAN

For (your name) _____

People that participate in therapy sometimes experience one or more of the following conditions: - self-harm (thoughts/feelings/behaviors to cut, hit, burn self, etc.)
- suicidality (thoughts/feelings/behaviors to end ones life)
- aggression (thoughts/feelings/behaviors to yell, break things, threaten, hurt others) - homicidality (thoughts/feelings/behaviors to end someone else's life)

If you ever experience such thoughts, feelings or behaviors, this document is intended to facilitate you in seeking out help and assistance.

By signing this document you are agreeing to the following statements and actions:

1) I understand that there are people available to help me
2) I also understand that getting the help and assistance I need might take some time.
3) I agree not to do anything to harm myself or others in any way while I am seeking out help and assistance. This includes any kind of overt or passive acts of danger to myself or others.

4) Overt acts are intentional acts to harm myself or others. Passive acts involve putting myself or others in possible danger such as not looking when crossing a street or engaging in unprotected sexual activities.

5) OPTIONAL: (_AGREE,__DO NOT AGREE) I agree not to partake in alcoholic beverages in order to remain clear-minded as to my actions.

6) OPTIONAL: (__AGREE,__DO NOT AGREE) I agree not to partake in any recreational drugs/substances in order to remain clear-minded as to my actions.

7) If at any time, I should feel unable to resist impulses to self-harm, to act out aggressively, to engage in suicidal behaviors or to engage in homicidal or harmful behaviors towards others, **I will first call 911** and then I also may one of the following:

A. Call Ridgeview Institute at 770-434-4567
B. Call Peachford Hospital at 770-455-3200
C. Go to an Emergency Room of my choice

I will agree to then call and leave a voicemail for Yori Aiyeola-Scott, LPC at 470-863-8536

This Crisis Management Plan begins immediately and will remain in effect for the duration of your therapy with Yori Aiyeola-Scott, LPC,. Your agreement to this plan illustrates your commitment to work through any thoughts, feelings, and behaviors at this time as well as in the future.

Your signature below indicates that you have read and understand what is being requested of you, and you agree to uphold this Crisis Response Plan without exception.

Recipient of Services Printed Name _____

Signature _____ Date_____

Therapist Signature and Date _____

Our Agreement….

I have read or had read to me all the information in this paperwork. I understand the information, have had a chance to review and ask questions and have had all questions answered to my satisfaction. I have read, filled out, and signed the Crisis Response Plan. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received the HIPAA notice form mentioned herein.

Printed name of adult client, child client and/or child client's legal guardian

_____

Signature of client or client's legal guardian if client is a minor

Date

Signature of Therapist

Date

CLIENT CONTACT INFO:

Client Printed Name _____

Signature _____

Date _____

Date of your first counseling session with Yori Aiyeola-Scott, LPC

_____

Home phone_____ Cell phone Approval to leave voicemail? __

Person in case of emergency you authorize me to contact (name, relationship and number)

Mailing Address Approval to mail to this address?

Email Address Approval to contact you via email?

Who referred you to me?

What is the primary reason you are seeking counseling services at this time?

When did you first notice the issue/problem that brings you to counseling? (please provide a date if possible)

Are you currently on any medications and if so which one(s)?

Significant medical history:

Have you ever been in counseling before? If so, when and for how long?

If you have been in counseling before, what was your reason for discontinuing counseling?

What seemed to work for you in that counseling experience and what did not work for you?

What do you hope to accomplish by coming to counseling?

Anything else you would like me to know before we begin our work together?

Yori Aiyeola-Scott, MA, LPC, NCC
Therapy Works Counseling Services,
LLC Stone Mountain, GA 30087

Fees for Services Agreement

Every time I schedule an appointment with Yori Aiyeola-Scott, LAPC, ( ), I understand that I am entering into a contract with Therapy Works Counseling Services, LLC and for the professional time and services of Yori Aiyeola-Scott. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, confidential consultations with other professionals as agreed in writing by me to assist with my treatment.

I understand Yori Aiyeola-Scott's professional fee is $100 per scheduled session and I agree to pay this fee at the beginning of my session unless there has been a reduced fee agreement made. In that case, I understand that Mrs. Aiyeola-Scott and I have agreed to the following fee $100. I understand that Therapy Wrks, LLC does not reimburse for canceled appointments that were paid for in advance but that any such fees will be credited to your account and applied to future services provided.

I understand that Yori's cancellation policy requires 24 hours advance notice in order to be released from the contract for Yori's time and services of preparation for my session. I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged a $50 fee for the appointment. I hereby authorize Therapy Works Counseling Services, LLC to charge my **Visa/ MasterCard/ Discover/ American Express (circle one) credit card number** e xp. date cv code zip code if I indeed fail to observe this cancellation policy as I understand I am paying for preparation services rendered and time contracted for when I set the appointment. I also understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with Yori directly and request a waiver of this policy but I understand that Yori is not bound to grant that waiver and may by this contract proceed with charging my credit card as agreed herein.

Client (or parent/legal guardian of child client) Printed Name

Client (or parent/legal guardian of child) Signature and date

Therapist Yori Aiyeola-Scott's Signature and date

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date