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Office Policies and Consent for Treatment

Welcome to my counseling practice and I am looking forward to working with you. This document contains important information about my office policies including the professional relationship, confidentiality, session structure and cost, cancellation, and emergencies. My commitment to you is to keep you fully informed, uphold the strictest ethical and professional standards, and to answer any questions you may have.

Professional Relationship

Psychotherapy requires full participation from both the therapist and the client. In order for therapy to be the most successful the client should actively work on their goals and concerns. Psychotherapy can have both benefits and risks. Therapy may bring up unsettling or uncomfortable aspects of your life and you may feel emotions such as sadness, anger, or guilt, to name a few. Therapy also has many potential benefits including addressing specific problems, improving relationships, and reducing feelings of distress. Psychotherapy is a uniquely individual experience and therefore there are no guarantees as to what exactly you will experience during our sessions. If adequate progress does not appear to be happening over time (you are not meeting your therapy goals) it is my duty to refer you to another provider who may be more helpful to you.

It is extremely important that a client and therapist maintain a professional relationship. This means that a therapist and client may not engage in seeing each other socially (friendship), a sexual or romantic relationship, or a business interaction. Therapists are required to keep the identity of our clients 100% confidential. Therefore if I see you in public, I will not address you or say hello unless you speak to me first. If you choose to speak to me in public, I will respond but will never disclose the nature of our relationship or how we know each other.

Confidentiality

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI) as required by federal law and HIPAA privacy regulations. Your record will be stored in a locked file cabinet in my office. In addition, everything you share with me will be 100% confidential unless one of the following conditions are met: 1) you sign a release of information allowing me to speak with someone else 2) you are a danger to yourself or others 3) you disclose physical or sexual abuse of a minor, elderly, or disabled person 4) I am ordered by a judge to disclose information and an appeal to uphold privileged information is overturned.

Couples only: When I see couples the couple as a unit is my client, not each individual. Therefore I cannot keep secrets that may be revealed to me in an individual session, by email, or a phone call (an example of a secret would be something like an affair, addiction, or legal trouble). If a secret is revealed to me that I think is important for your partner to know in order for you as a couple to meet your goals I will encourage you to share this with your partner. If you are unwilling or unable to do so please be aware that in some circumstances I may not be able to continue to work with you. In that instance I would refer you to another provider who could assist you. Please also be aware that any request to release information that is part of your record must be approved by both parties.

Session Structure and Cost

Sessions last for approximately 50 minutes and are \$130 per session. 90 minute sessions are \$180. Payment is due at each session. Brief, infrequent telephone and email contact is free of charge. Please note that complete confidentiality cannot be assured over email.

I do not currently participate as “in network” on any insurance panels. However, many people have out of network benefits meaning that you might be able to be reimbursed by your insurance company for a portion of your session cost. Please contact your insurance company directly to fully understand your benefits. I can provide you with a receipt to submit to your insurance company so you can seek reimbursement. However, please be aware that this will require my disclosure to them of your protected health information as well as the need to assign you a mental health diagnosis. There is no guarantee that your insurance company will reimburse you for part or all of the session cost and therefore full payment is your responsibility.

Email and Text Communication

Complete confidentiality cannot be assured over email and phone text communications as the possibility exists that they can be intercepted by an unauthorized party. Therefore please attempt to restrict your email and text communications to appointment scheduling issues. If you choose to email me about non-appointment related issues please be aware that I may not respond within the same day and/or may respond signifying that we should discuss your communication during a session. **Please do not use email to communicate an urgent or emergent issue.**

Social Media

I do not accept Facebook friend or LinkedIn requests from clients. Please do not use Facebook messaging to contact me. If you wish to contact me over email please use my professional email address.

Cancellation

As a courtesy please provide 24 hours notice if you must cancel an appointment. If you cannot provide 24 hours notice please let me know as soon as possible. After the second cancellation I will begin to charge a fee of \$50 for subsequent cancelled appointments.

What to Do In an Emergency

My practice is done on an outpatient basis, and designed to accommodate clients that are reasonably safe and have resources to contact in a crisis or emergency. Therefore, I cannot guarantee that I will be immediately available 24 hours a day/7 days a week. If either you or I feel that this level of support is not adequate, we can discuss additional resources or transfer you to a therapist that provides 24 hour coverage. **That being said, every effort will be made to respond to urgent phone calls the day they are received (non-urgent phone calls will be returned within 24 hours or less).** If this is an emergency and you cannot reach me immediately please call 911 or go to the nearest hospital emergency room.

Please indicate your understanding and acceptance of these policies and information by signing below. Your signature also serves as acknowledgement that you have received a copy of the HIPAA Notice of Privacy Practices.

Client's Name

Date

Client or Parent/Guardian Signature

Parent/Guardian Name (if applicable)

Couples: Each of you please sign a separate form