1924 Clairmont Rd Suite 200 ❖ Decatur, Georgia 30033 ❖ Phone: (678) 856-5031

BUSINESS POLICIES, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to You Are Worthy, Inc. This document contains important information about my professional services and policies. Please review it thoroughly and feel free to ask me any question that you might have.

Background Information, Theoretical Views & Client Participation

J.D. Jackson, is a Licensed Professional Counselor, National Certified Counselor and a Prepare Enrich Facilitator. Psychotherapy is about an inward journey and not a destination. My view on therapy is it's a temporary state with lifelong benefits. My role is to support you in moving beyond the pain, hurt, disappointment, frustration, and confusion to one of clarity, healing, and forgiveness.

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

Psychotherapy can have benefits and risks. Therapy at times, can involve discussing unpleasant aspects of your life. This may result in you experiencing uncomfortable feelings like sadness, guilt, frustration, and anger. Therapy can lead to solutions to problems, an overall reduction in feelings of distress, and better relationships. There are no guarantees of what you will experience, however we will work together to ensure that most of your goals are met.

In order for therapy to be most successful, it is important for you to take an active role, both during and between sessions. This also means avoiding any mind-altering substances including but not limited to alcohol and non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest; the greater the return.

Couples

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner if applicable. If any person from any party wishes to release the information in the clinical record, I require that both parties sign the release.

Cancellation/Missed Appointments Policy

Each session is approximately 60 minutes in length. Your appointment time is reserved especially for you. Please respect that there may be times when other clients are on a waiting list to be seen. **If you must cancel, please notify the office as soon as possible. If an appointment is missed or it is cancelled with less than 24 hours notice, you may be charged $25.00 or be charged for one of your EAP sessions.**

In Case of an Emergency

I am available to return routine and urgent calls within 24 business hours. Please note that I am often not immediately available by telephone. It is my policy to not answer my phone if I am with a client. When I am unavailable, my voice mail will be available for you to leave a message. If emergency mental health services are needed and I am not available to contact you immediately, call the emergency mental health number in your county (**Behavior Health Link-1-800-715-4225**), or go directly to the nearest emergency room or call 911.

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Client's Initials

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their client's secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

Termination Policy

People terminate counseling for various reasons. Sometimes termination is premature of goals being met, while at times counseling is terminated because goals have been accomplished. I want to ensure you that it is my policy to support all termination, for whatever reason. A case will be identified as voluntarily closed after mutual discussion between therapist and client(s) or if there has been no contact for 60 days.

Technology Statement

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential.

Text Messaging: Text messaging is not a secure means of communication and may compromise your confidentiality. Please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations. You need to know that I am required to keep a copy of all emails as part of your clinical record.

Statement Regarding Ethics, Client Welfare & Safety

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. With your participation, we will work to achieve the best possible results.

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Signing your name below indicates that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form as well as the "Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you.

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Client Name (Please Print) **Date**

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Client Signature

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Client Name (Please Print) **Date**

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Client Signature

The above signature(s) of the client(s) indicates that she or he has discussed this form with the therapist and had any questions regarding this information answered.

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Client's Initials