THERAPIST-CLIENT SERVICE AGREEMENT
Professional Disclosure Statement and Informed Consent to Treatment

Welcome to Affirmative Transformation Services, LLC. This document contains important information about my professional services and business policies. Although these documents are lengthy and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Psychological Services
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

My Responsibilities to You as Your Therapist
I. Confidentiality: With the exception of certain specific instances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I will always act so as to protect your privacy even if you do permit me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. As well, you may request anyone you wish to attend a therapy session with you. **Minors are granted the same confidentiality unless it puts them in danger. If something important that should be shared comes up in sessions, I will encourage the minor to disclose the information themselves, therefore maintaining confidentiality. I will support minors in this disclosure upon request.**

I consult with various experts in specific fields of mental health so that I can better serve my clients. I also participate in regular group consultation. If I consult on my work with you, I will not use your name or any information that can identify you. If there is any reason to believe you might know one of these professionals, I will tell you their name, so you have the option to request I do not consult with them regarding your care.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone who is doing this, I must inform Child Protective Services or the police within 48 hours.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police, the county crisis team, or someone who can ensure your safety. I would first explore all other options with you before I took this step.

4. I may use and disclose your health information in order to bill and collect payment for the services and items you may receive from me. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of

benefits), and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your health information to bill you directly for services and items. Usually, what is only shared is the type of service I provided, as well as a diagnosis from the DSM-V. (See III below)

5. Please keep in mind that although every safeguard possible is in place when using electronic communication such as email, computer, cell phone, or fax, I cannot guarantee there will be no interception. Nor can I protect your name when depositing your check at my bank if you choose to pay by check. As well, I file most insurance claims electronically, sharing your protected health information when required.

6. If you are filing a complaint or are a plaintiff in a lawsuit where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of these records in the context of the complaint or lawsuit. In spite of that, I will not release information without your signed consent or a court order. We can also discuss obtaining a protective order to help maintain the confidentiality of records. Please let me know if you are in this kind of situation so that I can take the utmost care possible to protect your privacy in my records.

II. Record-keeping: Records are kept in a secure location and on a secure server located at my office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. If you prefer that I keep no records, you must give me a written request to this effect for your file. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request.

III. Diagnosis: If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order for you to be paid. Diagnoses are the technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book title the DSM-V; I have a copy in my office and will be glad to let you read more about what it says about your diagnosis.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapists and Client(s) discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so the Client might experience life more functionally and fully. It provides an opportunity to better and more deeply understand oneself and the dysfunctional patterns that might be altered in efforts to improve how an individual feels, thinks, and functions. Psychotherapy is a joint effort between Clients and Therapists. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the Therapist will challenge the Client's perceptions and assumptions and offer different perspectives. Therapy does not, in any way, guarantee that there will be a "quick fix." During the therapeutic process, many Clients find that things get worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. The client should address any concerns he/she has regarding his/her progress in therapy with the Therapist.

Client Litigation

The therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. The therapist has a policy of not communicating with the Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in the Client's legal matters. The therapists will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary session rate of $125 for a 50- minute session.

Psychotherapist-Client Privilege

The information disclosed by Client, as well as any records created, is subject to the Psychotherapist-Client privilege. The Psychotherapist-Client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the Doctor-Client privilege. Typically, the Client is the holder of the Psychotherapist-Client privilege. If the Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, the Therapist will assert the Psychotherapist- Client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. The client should be aware that he/she might be waiving the Psychotherapist-Client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. The client should address any concerns he/she might have regarding the Psychotherapist-Client privilege with his/her attorney.

Audio and/or Video Taping of Session

It is often useful to audio and/or videotape sessions both to ensure that the Therapist is able to discover additional nuances of the session and for consultation purposes. Moreover, in some cases, such recordings might aid in the therapeutic process itself by allowing Clients to audit behaviors, tones, and information that they otherwise would be unaware of. The client reserves the right at any time to refuse audio and/or video recording during any and all sessions. In such cases where the client prefers not to be recorded, the Client should request this at the beginning of the session. Of course, should the Client decide after the session has begun, the Client still reserves the right to subsequently end the recording of the session. In any case, all recordings will be confidential as with any written records per the Confidentiality clause above. Recordings will be kept in password-protected format and will be destroyed once the usefulness of the recording has expired (in general, approximately 1 to 3 weeks). Clients are **prohibited** from written, video, audio, or electronically recording sessions.

Education, Training & Therapeutic Approach

I earned my Doctor of Psychology (PsyD) from California Southern University in 2019. I earned my Master of Science in Clinical/Counseling Psychology from Valdosta State University in August 2009 and a Bachelor of Arts degree in Psychology from Spelman College in 2007. Throughout both my undergraduate and graduate work, I worked in diverse therapeutic settings, including Oconee Community Service Board, River Edge Behavioral Health Center, Medical Center of Central Georgia, Great Expectations Unlimited, providing in-home intensive family intervention services. I currently work with military service members and their families. I hold the following licenses and certifications:

Georgia Licensed Professional Counselor ***(LPC007036)***
North Carolina Licensed Professional Counselor ***(14140)***
Mississippi Licensed Professional Counselor ***(2307)***
Texas Licensed Professional Counselor ***(83062)***
National Certified Counselor, National Board of Certified Counselors ***(320342)***
Certified Professional Counselors Supervisor ***(CPCS628)***
Approved Clinical Supervisor ***(ACS2472)***
Certified Anger Management Specialist II ***(1955)***
Certified School Counselor, Georgia Professional Standards Commission ***(1393590)***
Board Certified TeleMental Health Provider ***(309)***

I am also a member of the Licensed Professional Counselors Association of Georgia, American Counseling Association, and the Association for Counselor Education and Supervision.

My approaches to psychotherapy are grounded in cognitive-behavioral treatment, family systems, collaborative, and solution-focused, and a variety of techniques in therapy and will try to find what will work best for you. These techniques may include but not limited to, cognitive reframing, and training in mindfulness, emotional regulation, awareness exercises, self-monitoring, behavioral analysis, and journal keeping. If I propose a specific technique that may have special risks attached, I will inform you of that and discuss with you the risks and benefits of what I am suggesting.

Your Rights as a Psychotherapy Client

I. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to do what I'm 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 for working with your concerns and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

II. You have the right and responsibility to decide whether the proposed treatment plan will provide you with the treatment that you want. At any point during treatment, you are encouraged to let me know if something does not feel right, or if you want something else from treatment. Your input into the process of therapy, no matter how hard to put into words, is very important.

III. You have the right to confidential and safe treatment. As I said before, what you say to me is confidential unless I am concerned about your safety or the safety of another person.

Your Responsibilities as a Psychotherapy Client

I. You are responsible for coming to your sessions on time, and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling or cancel with less than twenty-four hours' notice, you must pay for that missed session, as well as the current session at our next regularly scheduled meeting.

II. You are responsible for paying the full fee for your session or your child's session at the beginning of each session unless we have made other firm arrangements in advance, or we have participating providers in your insurance plan. My fee is $125.00 for a fifty- minute session. Please let me know if you feel that the fee is unaffordable - I may be willing to make some adjustments depending on your personal circumstances. You must provide your insurance card at your initial appointment so that we may keep a copy of your record in accordance with our contract with the insurance company. If we decide to meet for a long session, I will bill you prorated on the hourly fee. Emergency phone calls are normally free. However, if we regularly spend more than fifteen minutes weekly on the phone, I will bill you on a prorated hourly basis.

1. We accept major credit cards, debit cards, and PayPal (Yolanda.king@a-transformation.com) and CashApp ($atransformation). We require a credit card (re-occurring billing) for clients paying out of pocket (will not utilize insurance or have no insurance coverage).
2. Please check with me to see if I can be reimbursed directly by your insurance company. If I am not a preferred provider under your insurance, I will help you as best I can so that you might be reimbursed by your insurance company. In that case, it is your responsibility to pay my fee and provide me with the correct forms and information necessary for reimbursement, unless otherwise arranged. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.
3. We utilize an invoicing service, and you will receive separate emails for invoicing and payments.
4. Verification of benefit coverage is not a guarantee of claim payment. All benefits are subject to the terms and conditions outlined in your contract with your insurance company. We have no authority to make representations to you regarding coverage of items or services covered.
    a. It is important that you understand your benefit coverage. For benefit coverage questions, please call the customer/member service phone number on the back of your insurance card. It is your responsibility, prior to your first appointment, to verify your plan's limitations, deductibles, and exclusions.
5. In compliance with health insurance contracts, Affirmative Transformation Services, LLC requires that all co-payments are collected at the time of service. This includes payments towards co-insurance and deductibles. In some cases, the co-insurance/deductible amount collected will be an estimate, and adjustments will be made once a response is received from your insurance company regarding the claim. This may result in a credit to your account or additional charges. We do not have the option to waive co-payments, deductibles, or coinsurance amounts due as that would be a violation of the contract we have with the insurance company.
6. It is your responsibility to provide us with updated information if your insurance company or plan changes or your coverage terminates. It is also your responsibility to notify us of any changes in address or other contact information. If the insurance information you provide to us is later determined to be inaccurate, resulting in a denial of your claim, you will be responsible for paying the amount denied by your carrier.

7. It is your responsibility to pay any charges not eligible and/or not covered by your insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.
8. You will receive an Explanation of Benefits (EOB) from your insurance company detailing charges, amounts you are responsible for, and amounts they have paid.
9. Utilization of insurance coverage limits the confidentiality of your treatment with Affirmative Transformation Services, LLC. We will submit all clinical and demographic information to facilitate claim submission and payment. This information includes clinical diagnosis, presenting problem, medication, and current stressors/barriers to treatment.

III. If, after termination, there is an outstanding bill, I expect you to pay it. If you refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

Appointments

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling or cancel with less than 24-hour notice, my policy is to collect the amount of your co-payment or the entire cost of the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Professional Fees

The standard fee for the initial intake is $175.00, and each subsequent session is $125.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash, check, or with a major credit card, via PayPal (Yolanda.king@a-transformation.com) or CashApp ($atransformation). Any checks returned to my office are subject to an additional fee of up to $35.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required, even if another party compels me to testify.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail, and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you need help sooner or if there is a life-threatening emergency, call the Crisis Line (800-715-4225), call 911, or go to the nearest hospital emergency room. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

Other Rights

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients. You have the right to file a complaint with the board in your respective state.

Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists
http://verify.sos.ga.gov/verification/
237 Coliseum Drive
Macon, GA 31217-3858

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
844.622.3572 (P)
336.217.9450 (F)
http://www.ncblpc.org.

Mississippi State Board of Examiners
for Licensed Professional Counselors
239 North Lamar Street
Jackson, MS 39201
Office: 601 359-1010

Texas State Board of Examiners of Professional Counselors
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin, Texas 78714-9347
E-mail: lpc@hhsc.state.tx.us
Telephone: (512) 834-6658

Consent To Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of diagnosis in billing, and to the release of that information to my insurance company if I request so. I agree to pay an initial intake of $175.00 and $125.00 per subsequent session at the beginning of each session or the co-pay of my insurance. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to undertake therapy with Dr. Yolanda King, PSY.D, LPC, NCC, CPCS, ACS, CAMS II, BC-TMH. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. King.

Your signature below I have read and understand all the information provided in this disclosure statement and have been provided an electronic copy of this *Therapist-Client Service Agreement.*

____
Signature of Patient/Personal Representative/Parent of Minor

____
Printed Name of Patient/Personal Representative/Parent of Minor

Date ____________________________________

Description of Personal Representative's Authority: ____