Multicolor Counseling and Consultation, LLC
Luis R. Alvarez-Hernandez, LCSW, CAMS-II
Psychotherapist/Licensed Clinical Social Worker
An Independent Practice at Athens Therapy Co-op
485 Huntington Road #196, Athens GA 30606 | 706-363-3352, ext. 709
luisalvarez@therapysecure.com | multicolorwellness.com

Please note the following policies and procedures. If you have questions about any of the following information, feel free to ask for clarification at your intake appointment. Please initial next to the arrows.

Informed Consent

I agree to be treated by the provider listed above. I understand that my participation in treatment is voluntary and that I can terminate services at any moment. I also understand that if I am court-mandated to engage in services, my termination of services can affect my legal case.

_____ I understand and agree to the information above.

Fees

Please note the following fees for services agreed upon by therapist and client(s):

- Intake session: $120/50 minutes
- Individual session/consult: $100/50 minutes
- Couples session: $100/50 minutes
- Phone/Telehealth sessions or consults: $100/50 minutes
- Group session: _____/session | *Group name:*

Other Specialized Services:

- Clinical Psychosocial Assessment: $175/50 minutes (Immigration, Diagnostics, etc.)
- Substance Use-Focused Psychosocial Assessment: $120/50 minutes
- Anger Management Assessment: $75/50 minutes
- Anger Management Session: $45/session
- Other:

Note:

Any changes in fees will be notified to clients 30 days in advance. A new Informed Consent Form will be completed then. I do not accept insurance at the moment. If you choose to seek counseling services that are out of network for your insurance plan, I will provide you with a statement so that you may seek reimbursement.

_____ I understand and agree to the information above.

Payments

You will be responsible for payment at the time of service. Payments can be made via cash, checks, or credit card. Please notice that we cannot control personal information obtained by credit card processors. Also, be mindful that your bank statement may list names of therapy services received or the name of this therapy practice. A $25 fee applies to every check returned due to insufficient funds. If an appointment cancelation does not happen with at least 24 hours notice, if you do not show up for your appointment, or if you are more than 15 minutes late for an appointment your credit card on file will be charged automatically for the cost of the full session. If a credit card is not on file, you are still responsible for the cost of the full session.

_____ I understand and agree to the information above.

Cancellation Policy

When we schedule an appointment, we are both committing to spend that time together. We all have emergencies from time to time, and if you and/or some else is sick I do not expect you to keep your appointment, but I would like for you to let me know so that I can offer your time to someone else. When you have other scheduling needs (baseball practice, family in town, big school project, etc.) please give at least 24 hours notice if you cannot keep your appointment. If you do not show up for your appointment or do not give 24 hours notice you will be charged for your appointment. If you are more than 15 minutes late for an appointment we will reschedule so that we can spend our full session together, and you will be charged for the full session. Please note that insurance cannot be billed for appointments that you do not show up for and you will be responsible for the full fee.

_____ I understand and agree to the information above.

Confidentiality

The content of what is discussed within the confines of your session are confidential. As outlined in HIPAA, in most cases I cannot and will not disclose any of your personal information without your written consent. The limitations of confidentiality include situations in which the counselor has reason to believe there has been an instance of child abuse or neglect, situations in which clients are deemed to be a threat to themselves or others, in case of emergency, or situations in which records are subpoenaed in a court of law. You will be provided a copy of the HIPAA privacy policy as it pertains to your mental health records. Additionally, there may be times when it is necessary and beneficial for me to staff cases with colleagues, though when that need arises no personal or identifying information is shared. Confidentiality extends to your therapist, other therapists and office personnel in the building, and interns who may work with this clinician from time to time.

To obtain a copy of certain parts of your record, please allow at least 7 days to process the written request. A Release of Information will need to be completed for every request.

_____ I understand and agree to the information above.

_____ I understand that I can find a copy of the Privacy Policy, which includes my rights and responsibilities, on the website multicolorwellness.com. I also understand I can receive a copy of the Privacy Policy, if requested to my therapist.

Parental Consent for Mental Health Treatment of a Minor

Minor's Name: _____	Parent or Legal Guardian's Name: _____
DOB: _____ Age: _____	Relationship to Minor: _____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed by Multicolor Counseling and Consultation, LLC. The mental health provider responsible for the care has explained to me the proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any. However, treatment will not be delayed if any emergency exists. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification. I also understand that treatment with the minor is a collaborative process between the minor, parent/guardian, and the clinician. Hence, some information may be kept private between two or more of the parties involved. The ultimate goal is for all parties to be able to communicate as honestly and freely with each other as possible.

_____ I, the parent or legal guardian, understand and agree to the information above.

_____ I, the minor, understand and agree to the information above.

Court and Legal Matters

The services provided to you (assessment, therapy sessions, etc.) are independent from any past, present, or future legal procedures. Engaging these services are in no way a guarantee of specific legal outcomes.

In cases that may involve court testimony, please be advised that my role is to help you and/or your family member find healing throughout this process. My priority is to honor the therapeutic relationship with you, as my client. It is not to gather evidence or to evaluate for custody, immigration cases, disability cases, or other legal disputes. Should you choose to subpoena me for court testimony in a civil or criminal case in order to testify as to my clinical experience with you or your family, the fee is $175 per hour, including travel and preparation time. Additional services, such as time spent speaking with attorneys or writing letters may be extra.

Please let your therapist know if you are currently working with an attorney, so that a Release of Information form can be completed and signed.

_____ I understand and agree to the information above.

Telemental Health

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. The internet, cell phones, and video conferencing have made therapy more accessible to more people than it has been in the past, but Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health and I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

I am required to inform you of the risks of using telemental health as it pertains to therapy. If we speak on the phone (whether via cell phone or land line), there is a risk that someone may overhear or intercept our conversation. Additionally, if anyone has access to your cell phone bill they may be able to see that we talked, what date we talked, and for how long. Telephone calls are billed at my hourly rate, and most insurance companies will not cover phone sessions. Text messaging is not a secure means of communication and may compromise your confidentiality. Therefore, I do not utilize texting in my therapy practice. It is the client's responsibility to use devices that are secure, as noted above.

If you wish to use email to communicate with me outside of session, my professional email account is luisalvarez@therapysecure.com. Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. If you are not using an encrypted e-mail account, there is the risk, as with emailing any sensitive data, that that information may be intercepted by a third party. The client assumes all risks associated with using email to send information.

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Skype is not a HIPAA-compliant format for video chat sessions, but at times I use a HIPAA compliant therapy video conferencing website. If you're interested in a telemental health session, I will give you directions on how to use this site.

_____ I understand and agree to the information above.

Contact

I am in the office by appointment only. If you have scheduling needs feel free to call the office at 706-363-3352, ext. 709 or email me at luisalvarez@therapysecure.com. If you have additional concerns that need to be addressed, we can schedule an in-person or phone session during normal hours of operations to discuss them. Payment is expected for all scheduled sessions.

It is my personal policy not to accept friend requests from clients or former clients via any social media networks.

Additional contact information is listed at the top of this document.

I'm required to notify you that I'm located in the Southeast and I abide by Eastern Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

_____ I understand and agree to the information above.

In Case of an Emergency

If you have a mental health emergency, you may call **9-1-1** or the **Georgia Crisis & Access Line: 800-715-4225**. Other crisis contacts include:

- **Lifeline**- (800) 273-8255 (National Crisis Line)
- **Crisis Text Line**- text "HOME" to 741-741
- **TrevorLifeline for LGBTQ individuals**- 1-866-488-7386
  - They also have chat and text options available: https://www.thetrevorproject.org/
- **Go to the emergency room of your choice**.

_____ I understand and agree to the information above.

Consent

By signing this form, I acknowledge that I have received and read the Informed Consent document provided. I understand that my PHI may be shared with necessary and appropriate parties for my therapeutic care. I agree to the terms of this document and agree to abide by these policies for the duration of our professional relationship. A copy of the HIPAA Notice of Privacy Practices has also been provided to me. An electronic copy of this document acknowledging my receipt of both items will be kept on file and will suffice in place of the original if needed.

Furthermore, if I am bringing a minor child in seeking therapeutic services, I consent to services on behalf of the child **AND** I acknowledge that I am the legal guardian of this child and I have the right to make medical decisions on this child's behalf.

_____ _____

Printed name of client | Printed name of client representative, if applicable

_____ _____

Signature of client or client representative | Date

Clinician: Luis R. Alvarez-Hernandez, LCSW, CAMS-II

_____ _____

Signature of clinician | Date

Important: Please provide a copy of this document to the client.
Importante: Por favor provea al cliente con una copia de este documento.