# *Candace Dale Mckenzie Counseling LLC*
# *Treatment Agreement*

***Candace Dale Mckenzie GA LMFT***
***4880 Lower Roswell Rd Ste 165, Suite 143, Marietta GA, 30068***
**404 620 1540** / ***cdmcounseling@gmail.com***

## Welcome!

Entering therapy is an important decision, and I am honored to be part of this journey with you. If after our first meeting, we decide to enter into a therapeutic relationship, it is important that you are made aware of the protections and limitations of this. We will review the following information together, and any questions can certainly be asked prior to our first session. If you are not comfortable with your rights as a client, and the limitations I may have as your therapist, we can discuss other options for treatment.

To begin, please know this document is known as an "**Informed Consent,"** and contains important information about the professional services and business practices of **Candace Dale Mckenzie Counseling LLC, and Candace Dale Mckenzie, GA LMFT.** Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us , but you may continue to ask questions and expand on clarification at any time.

## Step 1: Let's begin with some initial information.

Date: _____/_____/_____

Name: _____

Preferred Pronoun: _____

Address:_____

City: _____ Zip: _____

Phone (Home): _____

Work: _____

Cell Phone: _____

Birth date: _____ /_____ /_____

Social Security : _____ -- _____ -- ____

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Referred By: _____

Referral Phone Number: _____

Referral Email (if you have it) : _____

Emergency Contact: _____

Phone : _____

Relationship To Emergency Contact: _____

Physician: _____

Phone : _____

Physician Address: _____

Last examination date _____/_____/_____

Are you taking any medication or experiencing any health problems? Y/N (circle one)

If yes, please describe

_____

_____

_____

Have you been to therapy before? Y/N (circle one)

How long ago? _____

Previous Therapist's name _____

Previous Therapist's Phone _____

Previous Therapist's Email (if you have it.) _____

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If applicable, what DID you like about the previous therapy you received?

If applicable, what did you NOT like about your previous therapy?

Are there any fears surrounding seeking therapy, and if so what would those be?

Can you describe what you would like to address in therapy? We will expand on this in our session.

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This next question is called ***The Miracle Question*** in Solution Focused treatment. Take a moment to reflect on this question, as this may help to clarify our goals together.

"Suppose tonight, while you slept, a miracle occurred. When you awake tomorrow, what would be some of the things you would notice that would tell you your life had suddenly gotten better? If your problem magically went away how would your life be different?"

_____
_____
_____
_____
_____
_____

(Optional) In ways to focus on your narrative and individual needs, it would help to know if I may inquire about your background and support your core values. We can build on this as we work together, and I am open for knowledge in ways to stay as cultural sensitive as possible. As we build a therapeutic partnership, please feel free to redirect any statements from me that you feel are not aligned for you.

Is there anything I may know about your background that would help me stay as sensitive as possible to any diverse issues or values surrounding your culture, race, religion, spirituality, relational, age, gender, orientation, physical abilities, or socio economic status?

_____
_____
_____
_____
_____

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**Sep 2: Below is pertinent information of my services and your role. Please initial when noted:**

***Psychological Services:*** Your services will be provided by Candace Dale Mckenzie, CA and GA Licensed Marriage and Family Therapist.

***Assessment & Treatment***: Our initial sessions will involve an assessment of your needs. Typically, this evaluation will last from 1-3 sessions. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. Treatment may be time consuming, and since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like fear, anxiety, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who take part in it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience. You are entitled to ask questions about all aspects of treatment. If you have questions about my procedures, we can discuss them whenever they arise. I will be happy to help you secure a consultation with another mental health professional whenever you request or if I recommend it.

***Please initial***

***The Client's Role:*** You will be expected to play an active role in your treatment, such as working with me to outline treatment goals and/or completing questionnaires at the beginning of treatment or periodically during treatment to assess your progress. You will be asked to complete homework assignments between sessions, and your willingness to do this can be an integral part of a successful treatment. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with me, and I will attempt to resolve any difficulties that have arisen and arrive at a treatment plan that better meets your needs.

Please know, that if after time there has been no progress in your treatment goals, I may terminate our treatment for your wellbeing, and will offer appropriate referrals that can support you .

***Please initial***

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***Boundaries of the Therapeutic Relationship:*** The therapeutic relationship is unique to any other kind of relationship. For your protection, and to preserve the integrity of our work, there are certain boundaries, which are held in therapy. You are expected to come to therapy, live up to your financial obligations, and be honest in our work together. You will never be asked to engage in any kind personal relationship with me, and I would be unable to do so with you. Although therapy work can be extremely personal and meaningful, the relationship will always remain professional. We will only meet in my office and only at scheduled times, unless we decide to work via teletherapy (online). You will then receive a separate informed consent for this.

Once therapy is terminated, we will then be unable to have a relationship other than a therapist/client relationship. This ensures the preservation of the therapeutic relationship if you should ever choose to return to therapy. We can discuss any particular feelings you may have in response to these therapeutic boundaries. In fact, this is an important part of the therapy process to address this, if and when it becomes an issue.

***Please initial***

***Meetings:*** My therapy sessions are scheduled as full 60-minute or 90 min sessions once a week, or as your treatment needs dictate and we agree.

***Please initial***

***Cancelations:*** Cancellations must be made at least **24 hours in advance** in order to avoid being charged for the appointment time. Sunday appointments require **48 hours notice**. Please know, therapists/psychiatrists schedule blocks of time, and if someone doesn't show, we cannot see another client, as that time is lost. This can at times be an emotional and controversial subject, but know the action to charge for a missed appointment does not mean that you are being blamed. It is simply the structure of a business. Also, because wireless communication is not 100% reliable, my policy is that no appointment should be cancelled, unless it is confirmed by me in a written email response to you.

Please also know, if there are excessive cancellations, I may terminate treatment, especially if it is clear that you are not benefitting from treatment due to no shows.

***Please initial***

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***Emergency Situations:*** Please know, there are rare cases when I need to cancel an appointment due to a clinical emergency or unforeseen circumstances. Please note, if I need to cancel our appointment **within 48 hours of your session time**, then I will **NOT** charge you in anyway, and your next session will be comped.

***Please initial***

***Professional Fees & Payment***: Sessions are $**200.00 for 60 mins** and $**250.00 for 90 mins.** You agree to provide payment for services, either in the form of a credit card or cash at the end of each session. I also accept personal checks, but if they bounce, your CC on file will then be processed with bank fees.

***Please initial***

***Payment is due at the time of the session :*** Payment schedules for other professional services (eg: report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, and preparation of records or treatment summaries) will be agreed to when they are requested.

***Please initial***

***Insurance Reimbursement:*** Please know I am not in network with any provider, nor do I accept insurance. However, if you do have behavioral benefits and elect to seek reimbursement for your treatment, please let me know this by the end of the first session, and I will provide a superbill to you.

Please note, when you seek reimbursement, most insurance companies require that I release any and all pertinent information regarding your treatment, including but not limited to, diagnosis, treatment plan, treatment progress, number of sessions attended, social security number (for identification purposes), and medications you have taken. In addition, you must be aware that once information is released to the insurance company, I cannot guarantee that it will remain confidential. Before I send any information to an insurance company, I will discuss with you the information to be disclosed, and will obtain your written permission to release the information to your provider.

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Lastly, please know I will do my best to construct a superbill for you to submit, but I cannot guarantee that your provider will reimburse you, nor am I able to find who covers your behavioral benefits for counseling services. (Many large providers have exchange programs that may not be listed on your card.) If after our first session you would like to utilize an in network provider for your counseling services, I will gladly do my best to find a referral for you.

***Please initial***

***Confidentiality*** **:** In general, the privacy of all communications between a client and a psychotherapist is protected by law, and I can only release information about our work to others with your written authorization.

***However, there are a few exceptions:***

1) In most legal proceedings, you have the right to prevent me from providing any information about your treatment. However, in some proceedings involving child custody, and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

2) There are some situations in which I am legally obligated to take action to protect others from harm, and therefore, I must reveal some information about a client's treatment. For example, if I believe that a child, elderly, or a disabled person is being abused, I must file a report with the appropriate state agency.

3) If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

4) If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

Please know, these situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action, unless I deem discussing this may cause undo harm to the assumed victim.

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Lastly, while this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our first meeting. I will be happy to discuss these issues with you, as the laws governing confidentiality are quite complex. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues, but know I am not an attorney.

***Please initial***

***Professional Records:***
The laws and standards of my profession require that I keep treatment records. The information in the chart includes demographic information, a description of your condition, your treatment goals, your treatment plan and progress in treatment, dates and fees for sessions and notes describing each therapy session. As these records contain information that can be misunderstood by someone who is not a mental health professional, it is my general policy that patients **may not review them**; however, I will provide at your request a **treatment summary**, unless I believe that to do so would be emotionally damaging. If that is the case, I will be happy to send the summary to another mental health professional who is working with you. Patients will be charged an appropriate fee for any professional time spent in preparing and responding to information requests. These fees will be discussed with you prior to delivery.

***Please initial***

***Contacting Your Therapist*:**
You are welcome to contact Candace Dale Mckenzie, LMFT at **(404 620 1540.) In the event of a life-threatening emergency or imminent danger, please call 911 immediately**. For all other urgent matters or clinical emergencies, you can reach Candace first by calling **(404 620 1540)** and leaving a detailed voicemail message. In your message, please slowly and clearly state the nature of the situation, any important information, and your call back phone number. Again, in the event that you are experiencing a clinical emergency and Candace Mckenzie has not responded, please call 911 for assistance. Please do not text, but instead leave a voice message.

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***Out of Office*** **:**
If I am out of town or unavailable for any reason, I will provide coverage by a colleague and an announcement of such coverage will be made on the outgoing message of my voicemail system. I agree to take all reasonable precautions to ensure that all voicemail messages are returned within 24 to 48 hours, unless I am out of town, and that all emergency calls are returned as soon as possible. Please note, however, that as with any voicemail system, technical problems may occasionally occur. Again, for urgent matters, as described above, if I have not responded, please call 911 for assistance.

***Please initial***

***In Regard To Emails and Texts:*** I requests that you only send emails regarding **non-urgent matters** that we have previously discussed. In addition, you should never send via email or text any information that you would like to be kept confidential. Please know that though I do my best to adhere to Hipaa compliance, I cannot guarantee 100 percent confidentiality with emails, nor with texts, due to the ever-growing glitches and nuances in technology. Therefore, for all urgent or emergent matters, and for any communication of confidential information, please **only phone my office if needed**.

In regard to text, these may be utilized for appointment confirmations only, and again as stated before, I cannot guarantee confidentiality.

By signing this agreement and initialing, you understand my limitations in offering 100 percent confidentiality with text and emails.

***Please initial***

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***Acknowledgment :***

Please do not sign if you have any questions regarding the contents of this letter or if any of the information is unclear. I am happy to discuss any questions at length. Thank you.

"By signing below, I acknowledge that I have read Pages 1 -11 and understand the information presented in this 'Treatment Agreement' letter, and that I give my consent for treatment to Candace Dale Mckenzie, Licensed Marriage and Family Therapist. This consent shall remain in effect for the duration of my therapy, or until I provide written revocation of my consent to Candace Dale Mckenzie. I further acknowledge that I have received a copy of this agreement for my own records.

Client's Name:(Print) _____

Signature:_____

Date:_____/_____/_____

Parent if Client is Minor (Print) _____

Signature:_____

Date:_____/_____/_____

---

Candace Mckenzie Signature: _____

Date:_____/_____/_____

**Candace Dale Mckenzie**
Licensed Marriage and Family Therapist