ANCHOR OF HOPE COUNSELING
AUTHORIZATION FOR TREATMENT from Dr. Hope Threadgill, PsyD

This authorization for treatment form, which includes informed consent and confidentiality, is intended to make explicit your rights and responsibilities as a client.

1. I am requesting counseling services with Dr. Hope Threadgill of Anchor of Hope Counseling for myself and/or my child. I understand counseling sessions are generally 45-50 minutes in length. I understand that length and duration of counseling vary depending upon the type of issues presented. Many times length can be shortened if I follow through with agreed-upon outside work. Some counseling issues may require on-going maintenance. I agree to call ANMED Access Center (864-261-1819) after hours if I am upset. In a true emergency, I understand I need to go directly to the nearest emergency room or call 911. All appointments and cancellations will need to be made by phone, not emails.
2. I understand that I may terminate these services at any time, at my discretion, by choosing not to set another appointment. It is recommended that termination be discussed with Dr. Threadgill to allow for learning of healthy closure in relationships.
2. The intake or first session fee is $125.00. Fees for individual, couple, and family sessions are $ 110.00 per 45-50 minutes ($125.00 per 45-50 minutes for after hours and emergencies). I agree to pay this fee at the close of each session, which is customary. The minimum fee for court testimony is $500.00 first hour + $150.00 each additional hour plus travel time, and for depositions $400.00 first hour + $150.00 each additional hour to include travel. There are additional fees for reports and letters. I agree and **take full responsibility for paying all fees incurred from services received.**
3. Dr. Threadgill will provide me with a bill to submit for insurance and tax purposes. I understand that I will need to check with my company regarding the specifics of my coverage. I understand that Dr. Threadgill is not a Medicare or Medicaid provider. I understand that some insurance companies require a physician referral prior to reimbursement. I also agree to check with my insurance company for any pre-authorization that may be required and to inform Dr. Threadgill of the need to get pre-authorization before or the day treatment begins. I understand that insurance companies require a diagnosis, discussed with Dr. Threadgill, before reimbursement can be considered. Furthermore, I will provide the necessary referrals and forms for insurance, managed care, or other insurance coverage. Dr. Threadgill has my permission to electronically send or fax counseling information required for insurance authorizations, and to bill and collect payment from my insurance company when fee balance is outstanding.
3. I understand that counseling consultations require large blocks of time to be set aside for each client. Unlike physicians and dentists appointments, clients cannot be stacked in the waiting room. Therefore, I **agree to pay for any appointment canceled or missed without twenty-four hour notice**, except in the case of true emergencies.
4. I understand that my counselor may consult with other counselors in Anchor of Hope Counseling (AHC) as part of my case management and information will be kept confidential within the office of AHC.
5. I understand that if I or my child are prescribed psychotropic drugs (such as anti-depressants or anti-anxiety medications), or medication for ADHD, that it may be necessary for Dr. Threadgill to communicate with the prescribing physician. No such contact would be made without my written consent. I further understand that referral to a physician may be made if medication is indicated.
6. I understand that what I say during counseling sessions will be held in strictest **confidence**. However, I understand there are exceptions to this rule. All licensed practitioners are required by law to take action if they believe a client is a danger to him or herself, or to another person, and are also required by law to report incidents or credible allegations of child or elder abuse to the appropriate state agency. South Carolina Code 10-11-95. I understand Dr. Threadgill is subject to subpoena and that I may want to talk to her prior to considering legal action. Dr. Threadgill may contact my emergency contact person via phone for emergencies and to reach me. I understand that email messages, unless encrypted, may not be confidential.
7. No information about my case may be released without my completion of a written authorization, except under the conditions cited in Number 8 above, or in certain limited circumstances if my case record were subpoenaed or if authorizations are required for insurance payment. I understand that if I would like access to my file, I need to do so in writing and that I may examine my file while Dr. Threadgill is present to explain information to me.
8. I understand that Dr. Threadgill is a Licensed Professional Counselor and that she will abide by the regulations of SC Licensing Board for Professional Counselors in Columbia. Article 7 – Code of Ethics for Professional Counselors expands on the role of professional counselor to include counseling relationships, measurement and evaluation, research and publications, consulting, and private practice. SC Code of Laws, Title 40, Chapter 75 states that sexual intimacy between a practitioner and a client is prohibited (statement required by Board).
9. A large body of professional literature demonstrates that counseling is usually rated as helpful and effective by clients, though results cannot be guaranteed in any individual case.
10. DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

    IF YES, **WHOM**: _____**Phone**_____ You may revoke or modify this authorization with regard to any family member or other individual designed and revoking authorization must be put in writing. SC Code of Laws Section 44-66-75

Acknowledgement: I have read this treatment authorization, have had the opportunity to ask questions about the information it contains, and agree to abide by it.

_____ _____
Client Signature / Legal Guardian Signature and date