Dr. Tonya Sumner Brown
A Love Counseling Center, LLC
www.alovecounseling.org
www.alovecounseling@hotmail.com
404.316.0226

Information for Counseling Clients and
Agreement for Counseling

Please read thoroughly, initial the bottom of each page indicating you have read each page, note any questions you may have and we will discuss in your first session. After all questions are satisfied, you will need to sign the agreement in our first session. Please fill out the Client Information Form, the Privacy forms and the Fee Agreement as well. Make a copy of all of this paperwork for your own records.

About Bishop Dr. Tonya Sumner Brown…

Credentials:
Doctorate of Psychology (Psy.D.)
Masters of Divinity (M.Div.)
National Certified Counselor (NCC)
Licensed Professional Counselor (LPC)
Licensed Professional Christian Therapist (LPCT)
Certified Anger Management Specialists (CAMS)
Domestic Violence Intervention Specialists II (DVISII)
The Nurturing Programs Certified (NPC)
Clinical Pastoral Education Certified (CPE)

Licensed Specialist in:
- Oppositional Defiant Behavior
- Conduct Disorder
- Parenting
- Depression
- Anger Management
- Marriage and Family
- Family Violence
- Stress Management
- Rape Crisis Intervention
- Sex Offender
- Prostitution Recovery/ Trafficking
- Aging

- HIV/AIDS
- Grief/Loss/Bereavement
- Terminal Illnesses
- Pre-Trial Intervention
- Drug and Alcohol Intervention
- Post-Traumatic Stress Disorder (PTSD)
- Oppositional Defiant/ Conduct Disorder
- Attention Deficit Hyper Disorder (ADHD)

About A Love Counseling Center LLC…..

A Love Counseling Center is a limited liability company in the state of Georgia. Our mission is to create healthy persons, families, and communities by providing a safe, confidential and professional atmosphere; which is conducive to our clients exploring, learning and making adjustments; which will enable them to have deeper, richer, and more meaningful spiritual, physical and emotional life experiences. Christian counseling is available.

Benefits and Risks of Counseling….

Benefits of counseling have been shown by scientists in hundreds of well-researched studies. People who are depressed often find their mood lifting. Anxieties that prevent an individual from normal functioning can be mastered through techniques learned in therapy as well as opportunity to master "run-away" thoughts that are causing dysfunction. In counseling often people need and have a chance to talk things out or for children play out what is bothering them until their feelings are very naturally resolved. Clients' skills in relationships and communication often greatly improve. The greatest benefit to counseling in my experience is learning how to develop and maintain a sense of balance in life which yields more lasting contentment, satisfaction and skills for coping with the inevitable challenges life presents.

There is the risk that through counseling clients may at times feel uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding way to balance. It is not uncommon (especially with children) for symptoms to worsen before improving. Clients may recall unpleasant memories. Anytime we are making changes for the better, the familiar existing way of being in the world and in relationships is stirred up and turned upside down to some degree and there is the risk that significant others in one's life may have their own objections or negative reactions to a client's positive changes.
Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed. It takes great courage to begin the process

of counseling. If you have any questions about what to expect in your journey through counseling with me, I am more than happy to discuss this with you not only in our first session together but throughout the process.

Confidentiality….

It is a client's legal right that our sessions and my records about you are kept private. I will tell no one that you are receiving counseling services from me unless you give me express, written permission. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are some exceptions as follows:

Limits to Confidentiality:

1. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person. This usually means telling others about the threat including police officials.

2. If I have reason to believe a child or any adult dependent has been or will be abused or neglected, I am legally required to report this to the proper authorities.

3. If you are or will be involved in court proceedings and my records are ordered by a judge.

4. If a guardian ad litem (GAL) is appointed in a custody case involving child clients I have seen for counseling services and she/he is ordered by the court to have access to mental health practitioners and records therein, I am required to provide that information as it is court ordered.

5. The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

6. I am happy to provide paperwork for you to file with your insurance company; however, in doing so, there will be a diagnosis required with the paperwork and there may be a violation of your confidentiality as insurance companies do not always observe the same strict confidentiality polices that I do as a Licensed Professional Counselor.

7. Occasionally I see professional supervision or consultation with another licensed therapist as well as confidential peer consultation meetings with my fellow therapists. I share information about my cases and clients for the purpose of gaining further

perspective and ideas for how to best serve my clients without revealing names or identity. There may be a case where I share office space, record storage and voicemail system with a fellow therapists. Peers, fellow therapists and any supervisor are bound by confidentiality so that any information shared does not leave the room in which it is shared and full names are not revealed.

8. If you should choose to communicate with me via email or text I can not guarantee your confidentiality as sometimes an email remains on a server and may be accessible by others and text messages are held by the cellular phone service.

9. Due to the nature of cellular phone service, I can not guarantee your confidentiality when communication is by phone although I have taken every measure to password protect my phone and keep it on my person at all times.

10. In the case of my death or major medical incapacitation, all of my clients will be contacted and records will be accessed by a designated mental health professional who will ensure confidentiality.

VOICEMAIL POLICY:

I check voicemails throughout the day 7 days/week unless on vacation or out of country for any reason. I return calls Monday through Friday by 8:00 pm. I do not return calls on Saturdays or Sundays. My voicemail is tied to my cellular phone service. I cannot guarantee absolute confidentiality with regard to cellular phone service. My voicemail is password protected and secure to the best of my knowledge and ability. Please do not leave sensitive or detailed information in voicemail.

VACATION/TRAVEL POLICY:

When I am away from the office for vacation or business travel and I am unable to access voicemail and/or email I will notify you in advance and I will designate a professional counselor colleague to be on call in case of urgent and emergency issues.

SOCIAL MEDIA POLICY:

My professional ethics prohibit me from having virtual relationships with my counseling clients. I can not have you as a friend or connection on any social media sites. You may follow my blogs, sign up for my newsletters, like my professional social media pages but please never post anything on these pages or I will have to remove you in order to protect your confidentiality.

More on Confidentiality:

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations. In **working with couples and families**, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I ***will not be a "secret keeper" nor will I facilitate secret keeping.*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it or I may have to terminate the therapeutic relationship and refer you to another therapist.

Divorce and Custody Cases….

I am not a custody evaluator and can not make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.*

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you must agree before we enter a counseling relationship:

1. If I am seeing a child whose parents are in the process of divorce or who are already divorced, I require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

2. I will be available to provide an interview with a guardian ad litem (GAL) assigned to investigate the best interest of any child I am counseling upon production of court order demonstrating the GAL's right to examine your clinical record or speak with me. Otherwise, the adult client or parents of child client will need to sign a release for me to speak with the GAL. The client will be charged a full session fee for me to have such meeting with a GAL.

3. I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

4. Family sessions will likely be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

5. **I ask all my clients waive right to subpoena me to court.** This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child(ren). It is my experience that my appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

6. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of $175/hour of my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $175 per hour.

I understand these policies and I and any of my representatives now or in the future hereby waive any and all rights to subpoena Dr. Tonya Sumner Brown/ A Love Counseling Center's clinical record on any current or future legal proceedings.

Printed Name_____ **Signature** _____**Date**_____

Printed Name_____**Signature**_____**Date**_____

Scheduling and Cancellations (please also refer to Fee for Services Agreement):

I require 24 hours notice of cancellation of any appointment.

If a client does not arrive for a scheduled appointment or cancels inside of 24 hours,

there will be a charge for the full fee session. (please see attached Fee for Services Agreement for full explanation) On rare occasion there is what I consider to be a *true, absolute, unavoidable emergency* we can discuss and I most often will waive the charge.
Session parameters …

Parenting sessions and individual counseling sessions are 55 minutes.

Couples counseling and family counseling sessions are 55 minutes.

Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance…

Reduced Fees are available with application and are extended based on financial need and circumstances**.** A reduced fee agreement will be signed by both of us once application is approved.

I do accept all major credit cards for payment.

Payment is due at the beginning of each session.

Fee Structure: Standard Fees:
Our financial goal is that everyone who wants counseling can have it. We seek to work with our clients on an affordable plan.

Insurances: We are constantly adding new insurances, so please give us a call to see if we accept yours. Major insurances are Peachstate/Cenpatico, Amerigroup, Coventry/MHNet, MH Advantage, APS/ EAP and others.

- Evaluations: Pyschological $125

Substance Abuse/Anger Management, Parenting, Child Impact, Moral Reconation

- 1 Hr. $20 8 Hr. Comprehensive $85
  Anger Management/ Substane Abuse/ Moral Reconation/ Parenting/ Sex Offender
  Sliding Scale Fee: Poverty Level
- Initial Intake Session (90 minutes): **$ 150**
- Couples or Family Therapy Sessions (90 minutes long): **$150**
- Parent Session (50 minutes): **$85**
- Individual Adult or Teen Counseling Sessions: **$85**
- Court Related and/or Child Specialist Work for Collaborative Law Cases: **$200/hour of any and all time spent on the case.**

- Administrative Fee for Record Copy Requests: **$40**

I do require payment of fees be made at the beginning of each session so business can be out of the way in order to sink into the issues the client needs/wants to address during the session. Please have your check, cash or credit card ready before you come into session so we can take care of that before we begin your counseling session.

After Hour Support and Emergencies…

All calls after 7PM, will be routed to the on call staff.

You may call me during business hours on my mobile office number 404.316.0226 and leave me a confidential voicemail including your phone number even if you know that have it along with a brief message. I will call you back when I have finished all sessions and business with other clients or between sessions if possible and if not possible the same day that you leave the message, as soon as I can the next day.

When I am away from the office for extended time, my outgoing voicemail message will reflect when I will be back. I also provide all clients in advance my away-from-office dates.

If you have a life threatening emergency you should call 911 or go to the hospital of your choice. Only contact me in an emergency after you have already obtained emergency assistance from 911 or your choice of medical support

Other after hour Mental Health Resources
(not to be substituted for calling 911)
Georgia Crisis and Access Line 1-800-715-4255
Ridgeview Institute at 770-242-4567
Peachford Hospital at 770-454-5589
Cobb Mental Health Crisis Line 770-422-0202
Fulton Mental Health Crisis Line 404-730-1600

Clinical Records…

You should be aware that, pursuant to HIPAA, I keep information about all of my clients in a collection of professional records. This constitutes your **Clinical Record**. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session,

or have them forwarded to another mental health professional so you can discuss the contents. There will be an **administrative fee of $40** charged for confidential copying and mailing the record for release.

Client Rights…

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. I am happy to discuss any of these rights with you.

Complaints or Grievances…

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number:

Georgia Composite Board of Professional Counselors,
Social Workers, and Marriage and Family Therapists
237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

Our Agreement To Enter into Counseling Services….

I have read or had read to me all the information in this Information for New Clients. I have initialed all pages indicating that I have read them and understand them. I have had a chance to review and ask questions and have had all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received the HIPAA Privacy Policy notice form mentioned herein.

Printed name of adult client, child client and/or child client's legal guardian

_____ _____
Signature of client or client's legal guardian if client is a minor Date

_____ _____
Signature of Therapist Date

Client Information Form:

Name of Client_____ Client's Date of Birth _____

Date of your first counseling session with A Love Counseling Center, LLC
_____

Parent/Custodian if client is child_____

Home phone_____ Cell phone _____ Approval to leave brief message? _____

Mailing Address _____ Approval to mail to this address? _____

Email Address_____Approval to contact you via email to set up hushmail?___

How did you hear about me and my services?_____

History of suicidal attempt or thoughts?
_____

What is the primary reason you are seeking counseling services at this time?_____
_____
_____
_____

When did you first notice the issue/problem that brings you to counseling? (please provide a date if possible)
_____
_____
_____

Are you currently on any medications and if so which one(s)? Significant medical history:

Have you ever been in counseling before? If so, when and for how long?

If you have been in counseling before, what was your reason for discontinuing counseling? What seemed to work for you in that counseling experience and what did not work for you?

What do you hope to accomplish by coming to counseling?

Anything else you would like me to know before we begin our work together?

A Love Counseling Center, LLC

404.316.0226

PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: *treatment, payment, and health care operations.***

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The ***use*** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. ***Disclosures*** refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and health care operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request.

The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate form the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *my* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated

record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record." You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as "Business Associates." I do employ business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client's Rights and My Duties

You have a right to the following: • *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
• *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
• *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
• *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
• *The right to an accounting of non-authorized disclosures* of your protected health information;
• *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
• *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.
For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. ComplaintsI am the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.
Dr. Tonya Sumner Brown

Privacy Officer

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____

Client Signature or Parent if Minor or Legal Charge Date

Social Media Policy

Please be advised that my professional ethics prohibits me from having virtual relationships with my counseling clients.

I, therefore, do not accept friend requests or connection requests of any kind on any social media sites from my counseling clients.

I do have professional websites and social media pages. You may follow me, follow my blog, receive my newsletters on these sites and pages. Do not post any comments on these sites or pages, however. If you do I will be forced to delete the post and remove you as a follower in order to protect your confidentiality as my counseling client.

If you are a coaching client, these polices are not applicable. Coaching clients, consultation clients and supervisees are free to connect with me via social media.

I, _____, agree to abide by this policy.
(printed name)

_____ _____
(signature) (date)

Dr. Tonya Sumner Brown
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CLIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual home.

I wish to be contacted in the following manner (fill out all that apply):

Home Phone Number:_____

___OK to leave message with detailed information

___Leave message with name & call back number only

___ Do not leave message please

Cell Phone Number: _____

_____OK to leave detailed message

_____ Leave message with name and call back number only

_____ Do not leave message please

Work Phone Number:_____
___OK to leave message with detailed information

___Leave message with name & call back number only

___ Do not leave message please

Email: _____
___ OK to send scheduling or other general info not related to my counseling and not identifying me as a client
----- Please do not email me

Mailing Address: _____
__OK to send me PHI to this address
___ Do not send any PHI to this address

_____ _____
Client or Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

A Love Counseling Center, LLC

404.316.0226

Fees for Services Agreement

ALL CLIENTS MUST FILL OUT THIS FORM in its ENTIRETY PLEASE

Please note, your record including this form is kept in a locked and highly secure location

Every time I schedule an appointment with *Dr. Tonya Sumner Brown* I understand that I am entering into a contract with Wonders Counseling for Children & Adults, LLC (WCS) and for the professional time and services of Dr. Tonya Sumner Brown .

I recognize that professional services are not only provided during my appointment time but also prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, confidential consultations with other professionals as agreed in writing by me to assist with my treatment.

I understand that A Love Counseling Center's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time that A Love Counseling Center LLC and I have agree that my fee for sessions will be $_____ and I agree to pay this fee at the beginning of my session.

I understand that A Love Counseling Center s' cancellation policy requires 24 hours advance notice in order to be released from the contract for Lynn's time and services of preparation for my session.

I agree that if I fail to cancel my appointment inside of the 24 hour minimum time period prior to my session I will be charged a full session fee for the appointment.

I hereby authorize ALCC to charge my Visa/ Master Card/ Discover/ American Express (circle one) credit card number_____ exp. date_____ cvcode _____ zip code _

I also understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with Dr. Tonya Sumner Brown directly and request a waiver of this policy but I understand that Dr. Tonya Sumner Brown is not bound to grant that waiver and may, by this contract, proceed with charging my credit card as agreed herein.

I understand if payment is not made before or during my scheduled session I am hereby authorizing A Love Counseling Center LLC. to charge my afore-listed credit card for services rendered.

I understand this agreement authorizes A Love Counseling Center to charge my credit card for services requested and rendered outside of the office such as email counseling, phone sessions, preparation of documents requested by me or any court related proceedings.

Client (or parent/legal guardian of child client) Printed Name_____

Client (or parent/legal guardian of child) Signature and date_____