Anjana Freeman, MS LPC
Mental Health Consultant and Therapist
Rape Response, Inc

Client-Therapist Disclosure and Counseling Agreement

ABOUT ME

I am a Licensed Professional Counselor in the state of Georgia. My License # is LPC006434. I have a Bachelor of Science in Psychology from Kennesaw State University (2001) and a Master of Science in Clinical Counseling and Psychology from Brenau University (2006). During my career I've worked with survivors of sexual assault and domestic violence of all ages. I specialize in the treatment of trauma related symptoms such as anxiety, intrusive thoughts, compulsive behaviors, addictions, self-harming behaviors, relationship issues, and much more. I use a variety of treatment methods, but much of what I do is educate clients about the physiological effects of trauma (how their body and brain responds to traumatic stress) and help them learn new ways to balance and regulate these responses.

CONFIDENTIALITY AND REPORTING

Confidentiality means that I, Anjana Freeman, have a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, I am required by law to reveal information obtained during therapy to other persons or agencies without your consent. In such situations, I am not required to inform you of these actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor

I have read and understand my right to and the limitations of confidentiality.
_____ (please initial)

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

I am required by law to protect the privacy of your health information. Although your counseling record is the physical property of me, the information contained in your health record belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- inspect and obtain a copy of your health record
- amend your health record as provided by law
- obtain an accounting of disclosures of your health information as provided by law
- request communications of your health care information by alternative means or locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

I have read and understand my rights to privacy and access to my records under the HIPPA ACT.
_____ *(please initial)*

COMMUNICATIONS POLICY

Communication between you and I will be conducted with the upmost care and concern for your privacy and confidentiality. Emails, text messages, and voicemails require signed consent from you for each device or account used. Also, communication about your appointments or cancellations with anyone other than you requires signed consent from you.

It is my policy not to communicate with clients or accept friend requests from any current or former client on any social media sites such as Facebook, LinkedIn, Instagram, Pinterest, or Twitter. Additionally, I will not search for you on Google or any other search engine. Any information I gain about you should be of your choosing and on your own time.

I have read and understand the communications policy.
_____ *(please initial)*

THE BENEFITS AND RISK OF COUNSELING

One major benefit that may be gained from participating in counseling is resolving the concerns that brought you to therapy. Other possible benefits may be a better ability to cope with current stressors and gain a greater understanding of personal goals and values.

For survivors of sexual abuse, therapy is focused on resolving the symptoms of trauma, decreasing negative coping mechanisms while increasing positive coping mechanisms, and developing personal skills that will empower you to create a healthier life moving forward.

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There are certain risks involved in counseling. You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. Ms. Freeman will do her best to assess progress and provide referral to other sources if that is deemed necessary and appropriate. Psychotherapy is a collaborative process and the progress you make will depend in large measure upon your investment in the process.

I have read and understand the potential benefits and risks of counseling.
_____ *(please initial)*

SCHEDULING POLICIES

Therapy sessions are by appointment only. If you have an emergency, you should call 911 and then inform me at your earliest convenience so that we can arrange for your follow-up care. A counseling session will last 50 minutes. You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Cancellations must be made twenty-four hours in advance. More than 3 cancellations without adequate cause and/or notice may result in the termination of therapy until you have made arrangements to regularly attend scheduled sessions.

I have read and understand the scheduling policies.
_____ *(please initial)*

COMPLAINTS

If you have a complaint against me related to therapy, I encourage you to first discuss your thoughts with me so we can resolve the issue and increase the effectiveness of therapy and your ability to reach the goals you've set. However, if you believe I have violated an ethical code, you can file an official complaint through the Secretary of State of Georgia at http://sos.ga.gov/plb/submitcomplaint.php. Filing a complaint against me does not change any of the agreed upon standards of practiced outlined in this form.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING

I have read and accept this agreement and herewith consent to counseling/psychotherapy and appropriate treatment with Anjana Freeman, M.S. LPC.

_____ _____
Client Signature or Legal Representative Date

_____ _____
Anjana Freeman, M.S. LPC Date