

# Informed Consent – Supplemental Information

**Lisa Hedden, MS, APC, NCC**

**Phone: 404-994-1034**

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Welcome to the counseling process. My name is Lisa Hedden, and I am a psychotherapist with Compassion Cove Counseling, LLC practicing under direction of Practice Manager, Melanie Gulley, and supervision of Dr. David Lane. This document contains important information about my professional services and business policies. Please read it carefully and note any questions you have so you can discuss them with me during your intake. This document is supplemental to Compassion Cove Counseling Informed Consent for Treatment; it does not amend or replace the aforementioned document and is intended solely to provide additional information to you as a client. Once you sign this consent form, it will constitute an agreement between us.

## **Counselor Information – Lisa Hedden**

I have a Master of Science in Clinical Mental Health Counseling from Mercer University, a BS from Wake Forest University, and an MBA from Emory University. I have a passion for helping others accomplish their purpose and goals and believe this can best be achieved by providing therapeutic support as a mental health counselor. I am a licensed Associate Professional Counselor (#APC006597) in Georgia, and as such, I adhere to the ACA Code of Ethics, which is available for your review at <https://www.counseling.org/resources/aca-code-of-ethics.pdf>. I am also a National Certified Counselor (#1094963). I am a member of the American Counseling Association (ACA), the American Association of Christian Counselors (AACC), and the Licensed Professional Counselors Association of Georgia (LPCGA). I completed my counseling internship with Walden Behavioral Care and have worked in residential treatment for eating disorders, partial hospitalization, intensive outpatient programming, and outpatient therapy. I support the principles of Intuitive Eating and Health at Every Size. I am a certified Prepare/Enrich facilitator for pre-marital, marriage, and relationship counseling.

## **Nature of Counseling Services and the Therapeutic Process**

Psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the concerns that brought you to therapy, and the number of sessions will be determined based on your concerns and goals. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation. In order to obtain the most benefit from counseling, I recommend:

- Be specific about your concerns and decision to utilize counseling services
- Work with me as your therapist to establish your goals for therapy
- Discuss progress with your therapist and raise any concerns you have about the progression or nature of the sessions
- Actively participate, in an open and honest manner

If you have any questions or concerns throughout the process that you are unable to address with me, you may contact my supervisor:

W. David Lane, M.Ed., Ph.D., LPC, LMFT, NCC

Telephone: 770.810.5789

Email: [wdlane@compassioncovecounseling.com](mailto:wdlane@compassioncovecounseling.com)

I utilize multiple approaches to therapy based on individual concerns and needs. We will work together to establish goals and as your therapist, I will exercise judgment to work with you in achieving those goals. I may use behavioral and cognitive behavioral approaches, feminist principles that recognize individual needs, cultural norms, and gender biases, Adlerian principles, art therapy, narrative theory, emotionally focused therapy, and/or a family systems approach, among others.

I welcome all backgrounds, cultures, and faiths to the counseling relationship. If you desire, I will work with you to incorporate spirituality or your specific faith principles into the counseling experience. I hold a Christian worldview, and according to your preferences, may utilize standard counseling techniques in a way that is aligned with Christian teaching and values.

As your counselor, it is my ethical responsibility to maintain only a counseling relationship with you,

and not to interact outside of this relationship. Since we may encounter each other from time to time in our community, I will not acknowledge you unless you choose to acknowledge me first. In other words, I will take my lead from you. This is to ensure confidentiality and protect the nature of our relationship. In keeping with this professional relationship, my policy is to decline invitations of a personal nature, decline gifts, and decline social media requests. If you choose to follow me professionally through professional networking sites/pages, know this information will be public and could compromise the confidentiality of your relationship with me.

If counseling services are desired after termination, you may contact your private health insurance company or call the GA Mental Health Access line 1-800-715-4225.

### **Use of Technology**

My voicemail at the number listed on this form is confidential. However, due to the nature of text and email communication, I cannot guarantee the privacy of information you transmit. As such, please do not utilize electronic methods of communication for personal information. If you choose to text or email me, I will only respond to routine requests, such as scheduling, and will not counsel using these or other electronics means (e.g. Skype, FaceTime, etc.).

### **Fees, Cancellation Policy, Insurance**

Evaluation & initial intake appointment fees are \$150 for a 60-minute session. Individual and couples/family therapy sessions are \$120 per 50-minute session thereafter. Once your appointment hour is scheduled, you will be expected to pay for it (even if it is missed) unless you provide 24-hours advance notice of cancellation. If you are 20 minutes or more late to your appointment, it will be considered a no-show. Any outstanding fees must be paid before additional sessions can be scheduled. In circumstances of unusual financial hardship, please inquire about a sliding scale fee, in which case I would no longer provide a superbill for insurance purposes.

Credit cards are the only accepted form of payment, and payment in full is required at the beginning of each session. Payment schedules for other professional services will be agreed to when these services are requested and accepted.

If you have a health benefits policy, it will usually provide some coverage for mental health treatment when a licensed professional provides such treatment. All of my services will be considered “out of network” with your insurance provider. Please notify me before our first session if you will be utilizing insurance benefits; and then upon your request at each session, I will provide you with a superbill which you may file with your insurance company. However, you (not your insurance company) are responsible for full payment of the fee. Carefully read the section in your insurance coverage booklet that describes mental health services and call your insurer if you have any questions.

Please be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plans or summaries, or in rare cases, a copy of the entire record will be required by the insurance company. This information will become part of the insurance company’s files, and in all likelihood, some of it will be computerized. It is best to discuss all the information about your insurance coverage with me, so you can decide what can be accomplished within the parameters of the benefits available to you and what will happen if the insurance benefits run out before you are ready to end treatment. It is important to remember that you always have the right to pay for counseling services yourself (“self-pay”) if you prefer to avoid involving your insurer.

### **Couples / Family Counseling**

Please note that in couples and family counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with the other family members in counseling. When counseling a couple on their relationship, the relationship in and of itself becomes the client. For charting and insurance purposes, one member of the couple will become the identified client. This may require a diagnosis for that individual. The identified client and the collateral client may change places should the couple decide to use insurance benefits under the collateral’s name. Couples who are interested may use the Prepare/Enrich Program. This includes both parties taking a customized online assessment, and then our following sessions will be tailored specifically to the needs of the couple. Please let me know if this is something you are interested in. A one-time cost of \$35.00 would be due upon taking the assessment, payable online. It is recommended that you complete at least 8 sessions together as a couple after taking the assessment.

In order to best help the relationship, there should be no secrets. This would entail limiting our communication between scheduled appointment times. Should one of you disclose something to me in private, it will be my goal to help you communicate that to the other. An exception to this rule would be the disclosure of current physical violence. In such a circumstance, my primary goal will be to assist in finding the proper resources to ensure your safety. If records are asked for by a court of law or third party, due to confidentiality, both signatures will be required in order to release information. The same goes for any court appearances. As your couples Counselor, I do not recommend divorce. That decision, ultimately, lies with both of you. I ask the couple to commit to at least three sessions, as it can take the first two to determine the needs and goals of the relationship. It is my belief that anything can be resolved when both parties are open and honest, have the same goals, and participate in any assignments given. Should one or both of you decide divorce is inevitable, I ask that one or both of you begin seeing a separate Counselor, as continuing to see both of you may create a conflict of interest going forward. Also, if couples counseling is the ultimate goal, I may ask that both of you see a separate Counselor for individual counseling. In such a case, I will serve solely as your couples Counselor. I require a signed release to speak with any Counselor one or both you may be seeing individually to ensure we work together and not against each other.

### **Minors**

Regarding minors, please note that the minor child constitutes the client. I will provide treatment to children under the age of 14 only if the child agrees that I can share information with the parent or legal guardian as necessary. For children 14 and older, I request an agreement between the minor client and parent or legal guardian allowing me to share treatment progress with the parent/guardian; unless there is a safety concern as noted above, any other communication regarding counseling of the child will require the child's written permission. This policy is in place so that counseling can be a safe and secure environment for the child and facilitate open and honest communication. If you are a divorced or single parent of a minor child or are the legal guardian of a minor child or incapacitated adult seeking therapy, I may require documentation of legal authority to engage in a counseling relationship on behalf of the client or bring the client to counseling.

### **Additional Information**

From time to time, I may audio record our sessions and share information about our sessions with my

supervisor or in consultation with other counseling professionals. I will only share what is essential for consultation or case presentation and will not use your actual, full name or other personally identifiable information.

If you have any questions or concerns that prevent you from signing this document, please discuss them with me so that we can come to an agreement about your care and I can provide referrals to other providers, if necessary.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms. I will provide a copy of this document to you upon your request.

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Client Name – Please Print

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Client Signature

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Date

For Minors Only:

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Parent or Legal Guardian’s Name – Please Print

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Parent or Legal Guardian’s Signature

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Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

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Lisa E. Hedden

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Date