George Rinker, MS, MDiv

Licensed Clinical Mental Health Counselor

5H2 Doctors Park

417 Biltmore Avenue

Asheville, NC 28801

404-414-1465

Confidentiality, Disclosures and Consent for Treatment Statement

Client Participation:

I am very pleased that you have selected me to be your Professional Counselor, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding my background, business policies, confidentiality, emergencies, and certain issues regarding the therapeutic relationship.

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. In order for therapy to be most successful, it is important for you to take an active role, both during and between sessions. The more of yourself you are willing to invest, the greater the return. Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Qualifications:

George W Rinker, MS, MDiv., LCMHC (NC # 13911) earned his MS in Community Counseling from Georgia State University in 1996 and his MDiv. from Columbia Theological Seminary in 1991. He also holds BS in Business Administration and a BA in Education from Presbyterian College in 1984. Since his Licensure in the State of Georgia as a Professional Counselor in 2001 he has served over 20+ years in numerous profit and non-profit organizations as well as 18+ years in clinical private practice encouraging and supporting folks in their psychological growth. In addition, he has taught both undergraduate psychology classes and graduate level counseling classes in three universities in the Greater Atlanta area. George is also licensed in the State of North Carolina and has established a Private Practice in Asheville. He loves the mountains!

Counseling Background:

As a professional counselor I value the uniqueness of each person and in the strength and creativity of the human spirit. Within the counseling relationship is a safe place to define areas for growth, vent feelings, explore the many possibilities, find encouragement and move toward peacefulness. My approach to counseling is gentle and encouraging, although I can be direct when it is helpful. I will support without judging and am respectful of individual and/or cultural differences. My approach draws on many theoretical orientations that best suit the group or individual needs. I hold a certification in EMDR and assist folks in trauma resolution. In addition, I have extensive training in additions and recovery.

In my practice I have served many populations including teens and their families, adults, couples, relationships, gay/lesbian, elders as well as service to therapeutic foster children in a non-profit setting. I enjoy working with folks of all faiths, ethnic backgrounds, sexual orientations, philosophical views and do not discriminate among individuals. All services are confidential and professional, holding to the ethical standards of American Counseling Association and State Laws.

Client Responsibilities:

- Be on time for your scheduled sessions. Payment for service is due at each session.
- Give 24-hour notice of cancellation of a scheduled appointment or there will be a full Session $160 fee charged me.
- If an appointment is not kept and the client desires to continue therapy, I will call my therapist to schedule another appointment or all future appointments may be canceled.
- Follow the plan of therapy as set forth in your therapy sessions.
- Inform your therapist of any concerns regarding treatment, payment of services, desire to terminate services, job/salary, or any changes affecting therapy.

Session Fees and Length of Services:

Counseling sessions are 50-minutes in length and I operate on a fee for service basis with a current rate of $160 for each 50- minute session and there is a charge of the full fee of $160 payment without 24-hour notice of a session cancellation. In some cases I am able to offer a sliding scale fee for a session based on proof of need. Currently, I accept cash, personal check, and Venmo as forms of payment. And do NOT accept any charge cards or debit cards.

If I choose to use my out-of-network insurance I understand that it is my responsibility to bill my own insurance company myself and the practice of George W. Rinker, MDiv., MS, LPC does NOT correspond with the insurance industry in any way. I agree to pay the full fee for my therapy at the time of service. I will arrange for my insurance company to make direct reimbursement to me.

Other fees associated with counseling services are as follows:

*Letter writing on my behalf $90/30 minute or $160/50 minutes.
*Missed Appointment Fee is the Full Session Fee of $160 and payable before the next session is scheduled.
*Cancellation less than 24-hour is the Full Session Fee of $160.
*Returned Check Fee is $35/returned check or the Bank Fee if higher.

Use of Diagnosis:

If you choose to file your own insurance a quick bill receipt of your session will be given to include a psychological diagnosis if appropriate that is required by your insurance company for you to receive reimbursement. This diagnosis may become part of your permanent record with your insurance company and seen by many employees throughout your insurance company. George W Rinker, MS, MDiv., LCMHC is in no way responsive for the confidentiality or actions of your insurance company nor does he correspond with your insurance company in any way.

Some insurance companies will reimburse clients for counseling services and some will not. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before you are given your quick bill receipt, so you can file your own insurance for reimbursement.

Confidentiality:

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to harm another person(s), including murder, assault or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings and sexual abuse.
4. The client reports abuse of the elderly.
5. In the case of court ordered reporting for which the therapist is selective about disclosure.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communications between the therapist and client will otherwise be deemed confidential as stated under the laws of this state.

George W Rinker, MS, MDiv., LCMHC complies with the standards of **HIPPA Federal Laws** for maintaining confidentiality, privacy and client records. I understand that as part of my healthcare, George W. Rinker, MDiv., MS, LPC originates and maintains paper and/or electronic records describing my health history, symptoms, diagnosis and test results, treatment, and any plans for future care or treatment.

Client Emergency Plan:

Your therapist is accessible via telephone, email and voice mail. Messages are retrieved and returned daily, whenever possible, weekdays. Messages left on Fridays are returned on the following Monday. This office is not equipped to provide 24-hour emergency service. In the event that you experience a mental health crisis and your therapist is not reachable by phone you will need to contact emergency services at 911 or report to the nearest Hospital Emergency Room for immediate assistance.

Technology Statement:

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me to maintain your confidentiality, respect your boundaries, and ascertain that our relationship remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for me not to use a cell phone when contacting you, please let me know.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. If you choose to utilize texting or email, please discuss this with me. However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality.

I agree to brief: **Cell phone calls:________** (initial) **Texts:________** (initial) **Emails:_________** (initial)

Phone Counseling Sessions: (Optional)

I acknowledge that Counseling sessions by phone or Skype are totally optional and sometimes helpful in the case of situations of traveling, distance or life events that may arise preventing my attendance at the Counseling Office for a scheduled appointment. I understand that confidentiality may **NOT** be guaranteed when using technology as stated above in the Technology Statement. By signing here I give permission to use technology as in phone or skype when needed and understand the ramifications of such methodology for Counseling Sessions. Furthermore, I may terminate the use of such technology methods by presenting my written desire to stop such methods, signed and dated as to when such methods would stop.

By signing here I am agreeing to use Technology for Counseling Sessions should the need arise.

Signed:____ Dated______________

Phone Number to be used:__________________ Email to be used:______________________________ I am also in agreement to using Skype: ____________ (initial) Facetime:________________ (initial)

Note: Termination of this release of Phone Counseling Sessions may be granted at any time I choose but must be done in writing to: George W Rinker, MS, MDiv., LCMHC

Informed Consent for Telebehavioral Health

Telebehavioral Health involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information or conduct online counseling sessions for the purpose of improving patient care. As with any medical procedure, there are potential risks associated with the use of Telebehavioral Health. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the counselor.
- Delays in treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telebehavioral Health, and that no information obtained in the use of Telebehavioral Health which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telebehavioral Health in the course of my care at any time in writing.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding Telebehavioral Health and I hereby authorize George W Rinker, LPC to use telemedicine in the course of my counseling.

______________________________ ________________________

Signed Dated

Third party Payment for Client Services: (Parents paying for youth/children and/or any other payees other than the client)

I___________________________ acknowledge that all or a portion of my counseling services are being paid by a Third Party______________________________, relationship ________________. In so doing I understand that the Counselor, George W. Rinker, MS, LPC will have to bill and correspond (email, text or phone conversation) with the Third Party in order to receive payment for my Counseling Services. Correspondence may include a very general indication that I am attending my scheduled sessions, I am complying with my plan of therapy and generally that I am doing well. Details of my confidential counseling sessions will not be disclosed only information pertaining to payment and attendance on my behalf. My Third Party payer may be reached at: ________________ (phone) ___________________ (email). If I choose to terminate this agreement of Third Party Payment I will present it to my Counselor in Writing, Signed by me and Dated as to when this agreement is terminated. I agree:________ (initial)

Release of Confidential Information: (optional)

I ________________________________wish to allow release of my protected psychological/ health information to include diagnosis, dates of service, session notes/summaries, medications, counseling goals and all needed information to the following organization on my behalf:

Organization/Professional/Individual:____

Address:____

Email:___________________________Phone:______________ Fax:____________________

I fully understand and consent to such disclosure via mail, phone, fax or email.

Signed:________________________ Dated:________

Note: Termination of this release of Confidential Information may be granted at any time I choose but must be done in writing to: George W Rinker, MS, MDiv., LCMHC.

Consent to Treatment Agreement:

- I voluntarily choose to participate in psychotherapy at this time and I understand that I may terminate my therapy at any time without penalty.

- I have read the "Limits of Confidentiality" and compliance with HIPPA Federal Laws. I understand that I have a right to confidentiality in therapy and that information about me or my therapy may not be released to another party without my written permission. I understand the limitations of confidentiality regarding situations in which I or another person could be harmed, suspected neglect or abuse of a child or vulnerable adult, court order, professional consultation, and other exceptions as noted in this form. If I am using insurance I understand that my personal information may be required by the insurance company for payment of my services and I willfully release such information as needed.

- I have read, understand and agree to all of the terms and disclosures in this document and give my full consent to be engaged in the counseling process with George W. Rinker, MS, LCMHC, knowing that I may be subject to the emotional distress, pain and hard work of the issues that I bring to this therapy process. I agree to make payment at the time of services as outlined and comply with the treatment plan prescribed me. I agree to all terms in this document.

- If I am using my BCBS of NC that is accepted by George W. Rinker, MDiv, MS, LCMHC will I provide the personal information needed in order to file claims on my behalf as found in the financial agreement. If my insurance company fails to reimburse for my counseling sessions I am responsible for the outstanding balance. If there are problems with reimbursement I will be notified and it will be my responsibility to contact my insurance company and address the lack of payment issues myself. The practice of George W. Rinker, MDiv., MS, LCMHC will spend a reasonable amount to time with filing and addressing paperwork issues with my insurance company but if it becomes unreasonable the counselor may reject acceptance of my insurance and I will be responsible for full payment of my counseling sessions.

Complaints:

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Clinical Mental Health Counselors, P.O. Box 77819, Greensboro, NC 27417. Phone: 844622-3572 or 336-217-6007, Fax: 336-217-9450, E-mail: Complaints@ncblcmhc.org

______________________ ________________________ ___________
Client (Print name) Signature of Client Date

______________________ ________________________ ___________
Client #2 (Print name) Signature of Client #2 Date

____ ___________
Signature of Parent or Guardian Date

____ ___________
Counselor, George W. Rinker, MDiv., MS, LCMHC Date