# Informed Consent for Counseling Services for LivingWaters Personal Development, LLC

*This document provides important information about the counseling services offered through **LivingWatersPD, LLC** and your rights and responsibilities as a client. Please read it carefully and ask any questions before signing.*

**Clinician/Therapist**

Princess C. Lee, M.ED, LPC
LPC C013470,Georgia
2959 Chapel Hill Road
Douglasville, GA 30135
(404) 922-1962 | Livingwaterspd@gmail.com

**Therapist Qualifications**

Princess C. Lee is a Licensed Professional Counselor (LPC) in the State of Georgia and practices within the scope defined by state law and the state licensing board. Areas of competence, treatment approaches, and specializations will be discussed at the outset of treatment.

**Nature and Purpose of Counseling**

Counseling is a collaborative process that may involve exploring thoughts, feelings, behaviors, relationships, and life experiences to promote growth, insight, and symptom relief. Outcomes cannot be guaranteed, and some clients experience uncomfortable emotions as part of the process.

You have the right to:

- Ask questions about any aspect of counseling.
- Be informed of treatment options and recommendations.
- Accept or refuse any service, intervention, or recommendation, consistent with informed consent standards in counseling.

**Risks and Benefits**

Potential benefits may include:

- Increased insight and self-awareness.
- Improved coping skills and relationships.
- Reduction in distressing symptoms.

Potential risks may include:

- Experiencing strong or uncomfortable emotions.
- Temporary increase in distress when discussing difficult topics.
- Possible changes in relationships or life circumstances.

**You may stop counseling at any time, though it is often helpful to have at least one final session to discuss termination and referrals.*

**Confidentiality and Its Limits**

Information shared in counseling is confidential and will not be released without your written consent, except as required or permitted by law and professional ethics codes. Common limits to confidentiality include, but are not limited to:

- Suspected abuse or neglect of a child, elder, or vulnerable adult.
- Credible threat of serious harm to self or others.
- Court orders, subpoenas, or certain legal proceedings.
- Certain situations involving medical emergencies or as otherwise required by law.
- Supervision or consultation, where identifying information is minimized when possible.

***Questions about confidentiality and its limits can be discussed at any time.*

**Communication and Technology**

Phone/Voicemail: Voicemail is checked regularly during business hours, and messages are returned as soon as reasonably possible.
Email/Text: Electronic communication may not be fully secure, so it is best limited to scheduling and non-clinical matters.

Social Media: Clinical relationships will not be conducted or discussed via social media platforms, in line with standard professional boundaries.
In case of emergency, do not use email or text; call 911 or go to the nearest emergency room.

**Telehealth Services**

when services are provided via telehealth (video or phone):

- You are responsible for having a private, quiet space for sessions.
- Technology may have limitations (e.g., interruptions, security risks).
- You will be asked to provide your physical location at the start of each telehealth session in case of an emergency
- Telehealth is only provided to clients located in jurisdictions where the clinician is legally permitted to practice.

**Records and Privacy**

A clinical record is maintained for each client, including contact information, dates of service, basic session content, diagnoses (if applicable), and any releases or consent forms. Records are stored securely and retained according to state law and professional standards.
You may request access to your record, subject to limits permitted by law, and may request amendments or a treatment summary.

**Fees, Payment, and Billing**

- Session Fee: Standard fee is **$125.00** per **60** minute session.
- Payment: Payment is due at the time of service unless other arrangements are made.
- Insurance (if applicable): You are responsible for providing accurate insurance information and for charges not covered by your plan (e.g., deductibles, copays, denials).
- Nonpayment: Repeated nonpayment may result in pause or termination of services and may involve outside collection resources, consistent with risk-management advice for mental health practices.

**A detailed fee schedule and financial policy is available upon request and may be updated periodically.*

**Cancellation, No-Show, and Fee Policy**

Regular attendance supports counseling progress and helps reserve time specifically for your care. When you schedule an appointment, that time is set aside for you and is not available to other clients.

- Cancellation notice: If you need to cancel or reschedule, please provide at least **24 hours** notice (business days), by phone, secure message, or the practice's scheduling system.
- Late cancellations: Appointments canceled with less than **24 hours** notice may be charged a late cancellation fee of **$50.00**, which is generally not covered by insurance and is your responsibility.

- No-shows: If you do not attend a scheduled session and do not notify the clinician in advance, you may be charged a no-show fee of **$75.00**, which is not billable to insurance.
- Repeated missed appointments: Multiple late cancellations or no-shows may result in reduced scheduling options, a requirement for same-day payment before booking, or, in some cases, termination of services with appropriate referrals; risk-management guidance for counselors emphasizes documenting these expectations and any pattern of missed sessions.
- Emergencies and exceptions: Fees for late cancellations or no-shows may be waived at the clinician's discretion in the event of serious illness, accident, or other unavoidable emergencies.

**By signing this informed consent, you acknowledge and agree to this cancellation, no-show, and fee policy.*

**Minors and Custody (If Applicable)**

For clients under 18, consent from a parent or legal guardian is typically required, subject to state law regarding minor consent to mental health treatment.

- The parent/guardian with legal authority to consent to treatment must sign this form.
- Limits to confidentiality and how information will be shared with parents/guardians will be discussed at intake.

**Coordination of Care**

With your written permission, your counselor may communicate with your primary care provider, psychiatrist, school, or other professionals involved in your care to support coordinated treatment. You may revoke such permission in writing at any time, except to the extent that action has already been taken.

**Client Rights**

You have the right to:

- Receive services free from discrimination.
- Be treated with respect and dignity.
- Ask questions about your counselor's qualifications and approach.
- Request a second opinion or referral to another provider.
- File a complaint with the clinician, the licensing board, or other appropriate authority if you believe your rights have been violated.

The licensing and complaint authority for LPCs in Georgia is the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage & Family Therapists, which operates under the Georgia Secretary of State's Professional Licensing Boards Division.

Mailing address:
Professional Licensing Boards Division Georgia Secretary of State
237 Coliseum Drive
Macon, GA 31217
Main Professional Licensing Boards Division phone: (478) 207-2440

**Emergencies and After-Hours**

This practice is not a crisis service and **does not provide 24-hour coverage**, which outpatient mental health practices commonly clarify in informed consent documents. In an emergency:

- Call 911 or go to the nearest emergency room.
- You may also contact your local crisis line (such as 988, where available) for immediate support.

**You may leave a voicemail for the clinician, who will return the call as soon as reasonably possible during business hours.*

**Consent to Treatment**

By signing below, you acknowledge that:

- You have read and understood this informed consent document.
- You have had the opportunity to ask questions and receive answers.
- You understand the nature of counseling, including potential risks and benefits.
- You understand the limits of confidentiality.
- You understand the financial, cancellation, and no-show policies.

**You voluntarily agree to participate in counseling services with **Princess C. Lee, LPC**.*

Client Name: _____

Client Signature: _____ Date: _____

Parent/Guardian Name (if minor): _____

Parent/Guardian Signature: _____ Date: _____

Clinician Signature: _____ Date: _____