

METROPOLITAN COUNSELING SERVICES
2801 Buford Hwy, Suite 470
Atlanta, GA 30329

Signature Form

1. Acknowledgement of HIPAA Understanding

Your signature below indicates that you have read the information provided in the HIPAA Notice that is available in the waiting room, and understand its terms and conditions that are effective for the duration of the professional relationship between you and your therapist.

2. Acknowledgement of Informed Consent for Therapy

Your signature below indicates that you have received a written copy of the Informed Consent for Therapy, that you have read and understood it, and that you agree to its terms and conditions for the duration of your professional relationship with your therapist.

3. Acknowledgement of Interaction with the Legal System

- A. Your signature below indicates that you understand that your MCS therapist will not be involved or engage in any legal issues or litigation in which you are a party to at any time either during your counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litem, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system.
- B. Your signature below indicates that in the event that you wish to have a copy of your file, and execute a proper release, your therapist will provide you with a copy of your record, and you will be responsible for charges in producing that record.
- C. Your signature below indicates that you understand if you believe it necessary to subpoena your therapist to testify at a deposition or a hearing, you would be responsible for his or her expert witness fees in the amount of \$1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time spent over one-half (1/2) day would be billed at the rate of \$375.00 per hour including travel time.
- D. Your signature below indicates that you understand that if you subpoena your therapist, he or she may elect not to speak with your attorney, and a subpoena may result in your therapist withdrawing as your counselor.

4. Permission for Electronic Forms of Communication

- A. Your signature below indicates that you understand that secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact your therapist will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client.
- B. **Your signature below indicates that you understand that email should not be used for urgent communication.** Email and phone messages are not constantly monitored at Metropolitan Counseling Services. Instead, call your Therapist and leave a message. If your situation is life-threatening, or your Therapist has not called back in what you consider to be sufficient time, choose one of the following, all of which are available 24/7:
 - Georgia Crisis & Access Line (GCAL) at 1-800-715-4225
 - Ridgeview Institute Access Center at 770-434-4567
 - Dial 911 if your situation is potentially life-threatening
 - Or go to your nearest hospital emergency room

- C. Your signature below indicates that you understand that texting is not available to clients at Metropolitan Counseling Services.
- D. Your signature below indicates that you understand the transmission of video of any sort to your therapist or to MCS is prohibited.

4. Acceptable Modes of Electronic Communication

Your signature below indicates that you have selected acceptable forms of electronic communication.

Please check below which modes of communication are permitted and which are not permitted.

A. Voice communication to Client’s cell/smart phone for:

- Scheduling appointments ___Permitted ___Not permitted
- Appointment reminders ___Permitted ___Not permitted
- Between session contact ___Permitted ___Not permitted

If permitted, list permitted cell/smart phone number_____

B. Voice communication from Therapist’s cell/smart phone for:

- Scheduling appointments ___Permitted ___Not permitted
- Appointment reminders ___Permitted ___Not permitted
- Between session contact ___Permitted ___Not permitted

C. Contact via the Client’s email

- Scheduling appointments ___Permitted ___Not permitted
- Appointment reminders ___Permitted ___Not permitted
- Between session contact ___Permitted ___Not permitted

If permitted, list permitted email address(es):_____

D. Fax communication from MCS’s non-secure fax for:

- Scheduling appointments ___Permitted ___Not permitted
- Appointment reminders ___Permitted ___Not permitted
- Between session contact ___Permitted ___Not permitted

If permitted, list permitted fax number(s): **404-321-1928**

E. Fax communication to Client's non-secure fax or E-fax for:

Scheduling appointments ___Permitted ___Not permitted

Appointment reminders ___Permitted ___Not permitted

Between session contact ___Permitted ___Not permitted

If permitted, list permitted fax number(s): _____

Signature

I have read this Statement of Services, it has been adequately explained to me, and I understand its contents. I have read the HIPAA policies and informed consent for therapy and agree. I have designated electronic forms of communication which are acceptable to me.

By Client(s), including couples and family members as appropriate.

Print Name Here

Sign Here

Date

Print Name Here

Sign Here

Date

By (Therapist's Name)

Print Name Here

Signature

Date