

RINER COUNSELING

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THERAPUETIC CONTRACT

This form is to help define the terms of our relationship and to provide information about my professional services and related business practices. Please read, sign, and return this document at the start of your first appointment. Your signature represents an agreement between us, and please don't hesitate to write down any questions or concerns you may have so that we can discuss during your appointment.

Qualifications/Credentials:

I have a PhD in Counseling Psychology and School Psychology from Florida State University, an Ed.S/M.S. in Mental Health Counseling from Florida State University, and a B.S. in Psychology from Wofford College. I completed my pre-doctoral internship at the Johns Hopkins University Counseling Center and my post-doctoral fellowship at the University of Georgia Counseling and Psychiatric Services Center. I am licensed by the Georgia State Board of Examiner's of Psychologists.

Nature of Counseling Services:

I will tailor treatment to best meet your specific needs, and work to help you recognize personal strengths throughout the treatment process. My goal is to cultivate a safe, warm, and open space where you can be honest and genuine with any concerns or struggles being experienced. My ultimate desire is to facilitate growth, foster hope, and help you feel unstuck and supported throughout the process.

During the first session, I will gather information regarding your presenting concerns and overall life history. At the end of our initial session, I will provide general impressions and recommendations, and we will develop a treatment plan together and collaboratively. If a higher level of care is needed or you do not feel like I am the best fit, I will provide referrals with other highly trained professionals that can better meet or match your needs.

Psychotherapy sessions are typically scheduled weekly or biweekly, with each session lasting approximately 50 minutes in duration. Exceptions may include when working with couples, parents, or other family members. Over the course of treatment, we can decide whether to increase or decrease the frequency of sessions based on your current needs.

Therapeutic Approach:

My approach to treatment is collaborative, evidence-based, and tailored to best meet the needs of each individual. For therapy to be most successful, it is also important that you work on assignments in between sessions, such as writing in a journal or reading various handouts. In order to empower each client, foster insight, and create positive change, my therapeutic approach will rely heavily on the following evidence-based (highly supported by clinical outcome research) therapies:

- Acceptance & Commitment Therapy (ACT). Observing the futility of directing significant mental energy toward avoiding psychological pain, clients discover how essential this energy is to the pursuit of a fuller, more meaningful life – a life that fits with one's deepest values and brings lasting contentment.
- Cognitive-Behavioral Therapy (CBT). Learning shortcuts to recognizing and refuting overly negative thinking patterns, clients revise (develop more positive, realistic thinking) their typical ways of viewing themselves, other people, and the world.
- Interpersonal Therapy (IPT). The client resolves specific ongoing interpersonal difficulties (interpersonal role disputes, role transitions, grief reactions, or interpersonal deficits) that are impeding personal growth.

Consent to Treatment:

Treatment is voluntary; you have the right to terminate therapy at any time. Your therapist has the right to terminate therapy if:

- He/she believes the therapy being provided is no longer beneficial, that you will be better served by another professional.
- You are seeing another therapist, and participating in treatment with your therapist would jeopardize your progress.
- You fail to comply with the 24-hour clean and sober policy for more than one session.
- You repeatedly fail to follow treatment recommendations meant to protect your physical health.
- Your therapist reasonably perceives you as posing a threat to his/her physical well-being.
- You have failed to show up for your last 3 therapy sessions without providing 24-hours notice.
- You have a balance that is significantly past due. If, for any reason, therapy terminates, your therapist will provide you with the names of at least 3 other qualified providers.

Risk of Services:

Research shows the overwhelming majority of clients improve their situations through therapy. That said, know that therapeutic outcomes can never be perfectly predicted. Also, keep in mind that it is typical, and even healthy, to feel a little worse (usually for 1-2 weeks) before feeling better. Treatment is intended to induce change in your life and thus may disrupt your accustomed manner of living and/or relationships with others. Further, positive change takes work and you may be encouraged to try things that are difficult for you. Some people reach their goals quickly and with minimal discomfort, while others need more time and feel more stress during the process.

Probable Length of Services:

Although some clients elect to pursue long-term, in-depth treatment, most issues can be effectively addressed within 8-20 sessions, with weekly sessions followed in the end by biweekly or triweekly sessions. Please keep your therapist informed of your ideas/expectations regarding treatment length and session frequency. Clients who are highly motivated, come to sessions with specific topics to discuss, and continue treatment through assignments completed between sessions typically show the fastest and most enduring improvements.

Fees:

Payment is due at the end of each session. I accept cash, checks, and major credit cards, including Discover, Visa, and MasterCard. My standard fee is \$125 per hour. I do not charge for phone calls or brief consultations. Based on your financial needs, a sliding scale may be possible. I also offer reduced rates for college and graduate students. If you believe you are eligible for a reduced rate, please bring this up during your initial appointment. Please let me know 24 hours in advance if you need to cancel or re-schedule your appointment. If you fail to call or let me know, you will be charged a no-show fee.

To make things easier and simple, I strongly encourage you to complete an Electronic Payment Authorization form. This form is available on my website, or I am happy to give you a hard copy during our initial session. This form will allow me to automatically deduct your session fee from the designated debit or credit card you provide. This information will also be stored securely in your clinical file and can be updated or revoked at any point during treatment.

I do not accept insurance, although will provide you with a statement that you can submit to your insurance provider. I am also willing to complete any necessary paperwork for you to receive the mental health benefits to which you are entitled. Regardless of what your insurance company is willing to pay, you will be responsible for paying for me the sessions you receive.

24-Hour Clean & Sober Policy:

Your therapist is ethically required to terminate any session in which he/she believes a client is under the influence of, or has within the past 24 hours, used substances that impair his/her ability to participate in

treatment. With a client currently under the influence, the therapist will require that he/she not drive and make alternative arrangements to get home. If a client still attempts to drive, your therapist will immediately contact the police to follow and possibly arrest him/her for DUI/DWI.

Communication Between Sessions:

In an Emergency: If you are at risk of physically harming yourself or others, please immediately contact the 24-Hour Crisis Helpline 1(800) 400-1572 (on cell phone, dial 211), call 911, or go to your nearest emergency room. *Phone/Text Messages/Email:* You are welcome to email or leave voice or text messages at any time on my business line. I will attempt to reply within one business day (Monday-Friday). However, know that I am only free for a few minutes at a time. Also note that none of these forms of communication should take the place of face-to-face therapy.

Confidentiality:

Discussions between you and I are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where I have a duty to disclose, or where, in my best judgment, it is necessary to warn or disclose; fee disputes between myself and you; a negligence suit brought by you against me; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention when you and discuss this matter further. By signing this Information and Consent Form, you are giving consent to me to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding myself harmless from any departure from your right of confidentiality that may result.

Electronic Communication:

Email and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through their systems. And faxes can easily be sent erroneously to the wrong number/address. Please notify me if you decide to avoid or limit the use of email/fax communication. In addition, please do not use email or faxes for emergencies.

HIPPA:

The Health Insurance Portability and Accountability Act (HIPPA) is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that I provide you with a notice of privacy practices for the use and disclosure of PHI for treatment, payment, and health care options. The HIPPA notice is in a separate document, which is available on my website in the forms section. Please print a copy for your records, or I can provide you with a hard copy during our initial meeting.

By signing here, you acknowledge that you have read and understand the information in this disclosure, that you have discussed its contents with your therapist, Dr. Riner, and that you are entering (or are entering your dependent child/ward) into therapy in agreement with this policy. You also acknowledge being provided a copy (printed or online) of this document for your records.

Signature of Client: _____
Signature of Therapist: _____

Date: _____
Date: _____