

**G. Pat Stogner, M.Ed.**  
Licensed Marriage and Family Therapist

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1827 Powers Ferry Road  
Building 7 Suite 350  
Atlanta, Georgia 30339

Phone: 470-239-0718  
Fax: 770-818-5755

**Statement of Understanding**

I am pleased that you have chosen me as your therapist and I am committed to providing you the best possible care. In the interest of you having the most positive experience here, I have outlined some information about how I work.

**Confidentiality**

The fact that you come here and the things you tell me are kept in confidence with the following exceptions:

- Clear and present danger to self or others.
- Suspected abuse of a minor, elderly person or handicapped person (in which case I am legally required to report the incident to the proper authorities).
- Signed authorization by you to disclose information to a third party.
- Court order requiring my records.
- Discussions with peer professionals (without identifying data).
- If you are using insurance for reimbursement through “out-of-network” benefits I am required to provide a mental health diagnosis and any other information requested by the insurance company in order to process your claim. I have no control over the confidentiality of this information after it leaves my office.

**Payment Policy**

- Full session fee is due at the beginning of each session by way of cash, personal check, Visa or MasterCard
- There is a \$25.00 charge for returned checks.

**Structure and Cancellation Policy**

- Sessions are 50 minutes unless otherwise negotiated.
- Your appointment time is reserved for you. If you miss your session or cancel with less than 24 hours notice, the **full session fee** will be charged. The full session fee is \$130.00.

**I have read and understand the above information and agree to comply with the cancellation policy.**

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Signature

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Date