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Professional Disclosure Statement and Informed Consent

Qualifications/ Experience

Welcome to my practice. I appreciate the opportunity to be of help and look forward to us working together. This document is designed to inform you about my background and to ensure you understand our professional relationship.

I am a North Carolina Licensed Clinical Social Worker (#COO5360) with the North Carolina Board of Licensed Clinical Social Workers having earned my Master of Social Work (MSW) from the University of North Carolina at Charlotte. My experience includes working with children, adolescents, adults, families and groups in community-based as well as inpatient and outpatient treatment settings. My work, prior to entering private practice, focused on serving children/ adolescents and their families through Carolinas Healthcare System by providing school and community based therapy. In private practice I see adolescents and adults with concerns related to depression, anxiety, adjustments/life transitions, relational problems, eating disorders, school/work difficulties, women's issues, grief and loss, self-esteem issues, parenting difficulties and family conflict.

Philosophy and the Psychotherapy Process

As a clinician, I embrace a strengths-based perspective, and I borrow from many different theory bases for psychotherapy in aiming to understand and meet the individual needs of each person and of each family. These theories include cognitive-behavioral, solution-focused, reality-based, mindfulness-based and family systems theories. Techniques that I utilize may include dialogue, psycho education, relaxation, reframing of negative thoughts, positive decision-making, role-play, mindfulness or writing/art exercises.

We will work together to establish realistic and attainable goals for you to achieve. These goals are flexible and we may modify them throughout the therapy process as your needs change. Active participation in and out of session is essential to your success. I will often assign tasks between appointments to help strengthen the skills you acquire during therapy and empower you to resolve issues after the therapeutic relationship has ended.

In regards to length of therapy, an estimate for termination can be discussed during our sessions but it is just an estimate. Therapy is a unique process for each individual and duration and success of treatment will vary according to acuity of presenting issues. In saying that, you have the right to terminate therapy at any time. I ask that if you decide to discontinue therapy that you discuss this with me before doing so. Communication is essential to a healthy working relationship. The therapeutic environment should be one that is safe, honest, and respectful. Although we will be discussing personal and psychologically intimate information, our relationship must remain professional at all times. If you are dissatisfied with my services or feel that you have been

treated unfairly or unethically, please address this with me immediately. If you do not feel that you can address these concerns with me directly you can contact the North Carolina Social Work Certification and Licensing Board at (800) 550-7009 for clarification of client's rights or to register a complaint.

Fees and Billing

Individual counseling sessions will be billed at $100 per 60-minute session. Any additional services (consultations with attorneys, psychological reports, letters, and phone calls lasting more than 15 minutes) will be prorated at the hourly rate. Cash and personal check are acceptable methods of payment. Fees are due at the time of service, including co-payment for third party reimbursement. Claims will be filed for in-network benefits; however, filing out of network benefits will be the sole responsibility of the client.

In order to file claims with your insurance I am required to provide a diagnosis. Not all diagnoses are covered under insurance and when a diagnosis is given it becomes part of your health records. Please be advised that when you file with insurance you may be placing yourself at risk of being diagnosed with a preexisting condition. This may present challenges for future healthcare coverage.

A 24 hour notice must be given for cancellation or rescheduling appointments. A $50.00 fee will be assessed for any missed appointment without proper notice. There is a $30.00 processing fee for returned checks.

Records and Confidentiality

Information about you will not be disclosed without your prior knowledge and written consent. However, some limitations to this confidentiality do exist:

1. **Threat to yourself or others.** If you inform me that you intend to inflict harm upon yourself or others I am required by law to take actions necessary to prevent harm to any involved party. This includes the obligation to warn any person who may be placed in imminent danger by your actions.
2. **If mandated by court of law**. If you are involved in any court/ legal proceedings I may be subpoenaed to testify regardless of your consent. If required to appear in court there will be an hourly consultation fee for your therapist's time.
3. **Abuse**. If I am made aware of potential or actual occurrence of abuse or neglect I will be required to report this to the Department of Social Services.
4. **Insurance claims-** information about your treatment and diagnosis may be shared with your insurance company in order to pay claims.
5. **Supervision**. This counselor has a policy of supervision to help guarantee quality of service to you. Consequently, your case may be discussed with other counselors in supervisory group. Confidentiality is maintained by not disclosing any identifying information.
6. **Therapist has sole access to client records only. No other entity has access to client information.**

Consent for Treatment

- I acknowledge that I have received and read the above in its entirety.
- I am informed about the policy regarding confidentiality of information I may disclose during counseling and the limits of that confidentiality.
- I understand that no promises have been made to me as to the results of treatment provided by this therapist.
- I am aware that I may stop treatment with this therapist at any time.
- I understand that I will be charged based on the amount of time with my counselor and that I am responsible for payment at the time services are rendered. I understand that if payment for services is not made, the therapist may stop my treatment and my bill will be sent to a collection agency.
- I know that I must give 24 hours notice before canceling or rescheduling appointments to avoid being charged.
- I understand that whatever I discuss in treatment will be kept confidential with the exception of the conditions listed in the records and confidentially section.
- I am aware that information about my treatment may be shared with my insurance agency or other third party payer and **I authorize the release of any medical or other information necessary to process a claim.**

With agreement and full understanding and of these provisions, I give my consent to receive counseling services.

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Signature of Client or Parent/Guardian **Date**

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Printed name of Client or Parent/Guardian

_____ _____

Signature of Therapist **Date**