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Disclosure Statement

Thank you for the opportunity to serve as your counselor. My disclosure statement is designed to provide you with information regarding my educational and professional background. It will also ensure an understanding of our therapeutic relationship and the types of services I provide. Please read through this document carefully as it will inform you of my office polices and know that I am committed to providing you with quality, professional counseling and I am happy to answer any questions you may have.

My Qualifications – I received a MA in Professional Counseling in 2016 from Liberty University in Lynchburg, VA and a BA in Psychology with a focus in counseling in 2014. I have approximately three years of experience in the professional counseling field.
Licensure and Credentials – I am a North Carolina Licensed Clinical Mental Health Counselor Associate (LCMHCA), #A13247.
Restricted Licensure – As an LCMHCA, I am pursuing my full credentials and my services will be under supervision until that time. My supervisor is Dr. Don Bartley who is a Licensed Marriage and Family Therapist (LMFT) and works in his own practice in Asheboro, NC, 904 S. Cox St. Asheboro, NC 27203; (336) 626-0208
Counseling Background – I have approximately five years of counseling experiencing working with individuals, couples, families, and groups. Areas of treatment have included: personal, behavioral, emotional, and family issues. I take a person-centered approach to counseling and integrate techniques such as cognitive behavioral, dialectical behavioral, and play therapies. Areas of competence and services provided include:

*Child/Adolescent Counseling
*ADHD
*Anxiety/Stress
*Depression
*Transitions/Adjustments in Life
*Marriage and Family Counseling

It is my belief that for counseling to be effective, we must both be actively involved in goals set for the course of our counseling relationship. Please know that it may take some effort to change one's self-perceptions, emotions, and behaviors which means work both in and out of session. While counseling interventions provide potential benefits, there may also be risks involved such as uncomfortable feelings (guilt, anger, frustration, anxiety, guilt, etc.) as you process unpleasant aspects of your life or experience difficulties with others in your life as you work towards change. While I ask that you be aware of these risks, please also weigh them against the assets you may gain in your life by gaining insight into your life, developing skills, and equipping yourself with the ability to deal with life more effectively.

Session Fees & Length of Services – Sessions provided are 50 minutes in length and will be scheduled upon our mutual agreement. I agree to provide counseling services for a fee of $90-$150 per session. Payment is requested at the time of service. Cash and checks are the preferred methods of payment however, credit cards are acceptable for payment also. Health insurance may pay for a portion of service fees. If you choose to use insurance to bill for services, I am willing to fill out any reasonable forms for reimbursement which are provided by

you or your insurance company. You will be expected to pay any copay or deductibles owed at the time of your session.

If you are unable to keep an appointment, please contact me to cancel or reschedule at least 24 hours in advance. If I do not receive such advanced notice, unless you have an emergency, you are responsible for paying for the session that you missed. Please note that insurance companies do not pay for missed sessions, therefore you will be responsible for the entire fee.

Use of Diagnosis – Please be aware that some health insurance companies will reimburse clients for counseling services and some will not. In addition, most insurance companies will require a mental health diagnosis before they agree to reimburse for costs of services. Also, there may be some diagnostic conditions that may not qualify for reimbursement. As a professional counselor, I utilize the Diagnostic Statistical Manual of the American Psychiatric Association, Fifth Addition (DSM-V) when providing a diagnosis. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis given will become part of your permanent insurance records.

Confidentiality – Our conversations and the records I keep of our sessions together are private and confidential. However, there are a few circumstances in which I cannot guarantee confidentiality for legal and ethical which include: (1) When I believe you intend to harm yourself or another person; (2) when I believe a child or elder has been or will be abused or neglected; (3) I am ordered by a court to disclose information; (4) I am required to provide clinical to insurance or managed care companies; (5) I am working collaboratively with other professionals where disclosure of personal information is necessary to provide optimal care; (6) you are a minor for whom confidentiality is limited to the extent exercised by your parent/legal guardian.

Emergency Situations - If you have an *urgent situation*, which you feel needs immediate support and I am not available by phone, please contact your local 911 system or go to the nearest emergency room.

Complaints - Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007 Fax: 336-217-9450 E-mail: Complaints@ncblcmhc.org

Acceptance of Terms

If you have any questions, please feel free to discuss them with me. Please sign and date both copies of this form. A copy for your records will be returned to you. I will retain a copy for my confidential records.

Client: _____ Date: _____

Counselor: _____ Date: _____