



## **LCMHC Professional Disclosure Statement**

Dallas E. Johnson Jr., MS, LCMHC, NCC

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### **Disclosure Statement**

This is a statement of your rights and responsibilities for our therapeutic relationship. This document is part of the Standards of Practice of the North Carolina Board of Licensed Clinical Mental Health Counselors. The disclosure statement is designed to inform you of my professional credentials, types of services offered, fee schedule, and therapeutic orientation and style. Please let me know if you have any questions or concerns about this disclosure statement. You may revoke this agreement in writing at any time.

### **Client's Rights and Responsibilities**

As a client, you have the right to choose a counselor/therapist who best suits your needs and purposes. Please be advised that you may ask questions about treatment at any time. You may also choose to terminate/end therapy at any time by way of a written statement.

### **My Qualifications**

I received my Master of Science degree in Clinical Mental Health Counseling from Walden University in August of 2015. I am credentialed as a Nationally Certified Counselor, by the National Board for Certified Counselors, and I am licensed as a Licensed Clinical Mental Health Counselor (License#11973) by the National Board of Licensed Clinical Mental Health Counselors. I have had several year of professional private practice counseling experience and multiple years of pastoral counseling experience.

### **Counseling Background**

As a counselor, I have experience with working with all age groups and a variety of therapy concerns. Much of the issues that I work with children and teens on include behavior problems (at home and school), family problems (separation, divorce, and neglect), social services interventions, depression, anxiety, grief, and trauma (physical, emotional, and sexual). My experience working with adults includes assisting adults with depression, anxiety, marriage and family issues (separation, divorce, parenting skills), social services interventions, and trauma (physical, emotional, and sexual).



## **Services Offered**

As your counselor, I can see you in individual or family sessions. My primary theoretical orientation is Cognitive Behavioral Therapy (CBT), but I also use Client Centered, Existential, Eye Movement Desensitization Reprocessing (EMDR), Clinical Hypnosis/Hypnotherapy (HT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Collaborative Problem Solving (CPS), Child Parent Psychotherapy (CPP) and elements of Play Therapy. CBT and Client Centered approaches assist me in focusing on present issues that you may present within our sessions and help to formulate solutions to problems while focusing on your strengths. Existential therapy assists me in working with any future goals you may have and allows for focus on any spiritual aspects of life that may concern you.

EMDR and TF-CBT are primarily used to address any past or recent traumas that you may wish to discuss or work through. Clinical Hypnosis is often used in the treatment of habit cessation and pain management. Play therapy usually assists children in working through behavioral or emotional concerns. CPP is utilized to address children who have early childhood trauma. If you would like to know more about my theoretical orientation or treatments used, please ask me.

In the sessions, we often develop short- and long- term goals, and work with those goals in mind. On occasion, I will ask that you attempt homework assignments that I will provide as a way to further your progress. I will also ask that you discuss the experience of the assignment at the following session. Often, clients who contribute to their therapy by sharing honestly and working in and outside of our sessions see the most growth and completion of set goals.

## **SERVICE FEES AND LENGTH OF SERVICE**

**Sessions and Payment.** Your first session will last approximately 1 to 1.5 hours. Each subsequent session will last between 45 and 60 minutes. The fees *due upon service* are \$190.00 for the initial intake appointment and \$165.00 for each appointment following. You may pay for services rendered via Cash, Check, Visa, Master Card, or American Express.

**Third Party Payers.** As a courtesy, we will bill your insurance company, HMO, responsible party or third party payer for you if requested. We ask that at each session you pay your co-pay. In the event you have not satisfied your deductible, the full fee will be due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time.

**Cancellations and Emergencies.** It is expected that your session will begin at the agreed upon time. Any session that begins after this time due to late arrival (for *any* reason) cannot be extended beyond the agreed session end time. Please provide at least a 24 hour notice should you need to cancel or reschedule an appointment. Frequent missed appointments will



lead to additional charges that will not be covered by your insurance company or other third-party payers. Three missed appointments without prior notice can result in the termination of services.

If you experience an emergency situation for which you feel immediate attention is necessary, please contact me via my cell phone number or at 336-907-2050 to reach the Aspen staff member on call. If no contact can be made, you understand that you should contact the 24 hour mobile crisis hotline at 1-866-275-9552, Suicide Prevention Lifeline 1-800-273-8255, Emergency 911, or as a last resort, visit a local emergency room for services. You may also contact VAYA Health Crisis Line at 1-800-849-6127 or Partners Behavioral Health Hope Line at 1-888-235-4673. I will follow those emergency services with standard counseling and support.

### **Use of Diagnosis**

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition be made and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. 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 made will become part of your permanent insurance records.

### **Confidentiality**

All of our communications become a part of the clinical record, which is accessible to you upon request. Your verbal communications and clinical records are strictly confidential. You should be aware, however, that legal and ethical requirements specify certain conditions in which it may be necessary for me to discuss certain information about your treatment with other professionals. If you have any questions about these limitations, please ask me about them before we begin our sessions.

Confidentiality will be limited if/when:

- a. Information (diagnosis and dates of service) is shared with your insurance company to process your claims,
- b. You and/or your child(ren) report physical or sexual abuse of a child; then, North Carolina State Law obligates your counselor to report such incidents to the Department of Social Services,
- c. You provide information that informs your counselor that you are a danger to yourself or others (including child or elder abuse),



- d. You sign a release of information to have specific information shared,
- e. Information is necessary for case supervision or consultation, or
- f. Information is required by a court order to be disclosed.

### **Complaints**

Although clients are encouraged to discuss any concerns with me, complaints may be filed 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](mailto:Complaints@ncblcmhc.org)



## LCMHC Professional Disclosure Signature Page

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### Acceptance of Terms

We agree to these terms and will abide by these guidelines.

### Signature of Client/Guardian

	<b>Date:</b>
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### Signature of Counselor

	<b>Date:</b>
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