

Professional Disclosure Statement

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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 Professional Counselors (LPC) as noted in Section 90-343 of LPC Act. 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 Arts in Clinical Mental Health Counseling from Liberty University, in May of 2023. I currently hold a LCMHCA license as a Clinical Mental Health Counselor In North Carolina. I have one year of graduate counseling experience working as an intern, and have 5 years of experience working with children of all ages. I received a Bachelors Degree in Sociology from the University of North Carolina at Charlotte in 2018. I have many years of education in the fields of psychology, sociology, and counseling.

Restricted Licensure

I am licensed as a Clinical Mental Health Counselor Associate in North Carolina. I am under the supervision of Dallas Johnson, MS, LCMHC, NCC. Dallas can be reached by email at Dallas@aspenmentalhealth.com or by phone at 336-827-0089.

Counseling Background

I work with clients of all ages and backgrounds, and various mental health concerns. Some of these concerns include: Anxiety, depression, grief, interpersonal relationships, body image, and self-acceptance. I utilize a person-centered approach, and include elements of Cognitive Behavior Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Reality Therapy. My goal is to continue learning different therapy models to provide my clients with the best treatment.

Services Offered

I see clients for individual or family sessions. In the sessions, we develop short and

long term goals, to guide the therapy process. I will occasionally ask you to do homework assignments, to further enhance the skills learned in therapy. It is important to be working on your goals in session and outside of session to see the most growth.

Service Fee and Length of Service

Sessions and Payment: Your first session will consist of an intake lasting at least 1 hour. Each session following will last between 45 and 60 minutes. The fees due upon service are \$190.00 for the initial intake 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. Two 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 336-907-2050 to reach the Aspen staff member on call. If no contact can be made, by signing acknowledgement of this form you agree that 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, 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 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
Email: Complaints@ncblcmhc.org

Acceptance of Terms

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

Client: _____ Date: _____

Counselor: _____ Date: _____

