



PROFESSIONAL DISCLOSURE STATEMENT & INFORMED CONSENT

Philosophy and Experience: I've been a Licensed Clinical Mental Health Counselor Supervisor (LCMHCS #S10534) for six years. I work well with all ages from children to adults seeking mental health services. I've also been a Licensed Clinical Addictions Specialist (LCAS #14414) since April of 2014. My expertise is in mental health and substance use disorders (dual diagnosis), trauma, and crisis work for individuals and groups. With an eclectic approach to therapy, I may utilize cognitive-behavioral therapy, dialectical behavioral therapy, solution-based therapy, reality therapy, person-centered therapy, motivational interviewing, humor, and skills training. I am sensitive to those affected by trauma using a trauma informed approach. I also work foundationally from a Christian or spiritual perspective; however, I am not limited to working with different faith bases. Additionally, I work from a client focused and strengths-based perspective as I feel it is important to overcome challenges and make positive changes in one's life. I also believe that education, skill building, and self-awareness are integral to personal enrichment.

Formal Education, Training, and Licensure: I received my Masters of Arts Degree in Professional Counseling from Liberty University in May of 2010. Again, I am a LCMHCS with the NCBLCMHC as of December 2013 currently in good standing. I am also a LCAS with NCSAPPB as of April 2014 in good standing.

Length of Sessions, Fees & Methods of Payment:

Services are rendered in a professional manner consistent with prevailing ethical standards. Services offered are individual therapy in intervals 30 minutes per session; 50 minutes to an hr being standard. **Initial assessments & evaluations for therapy** is \$160 for individuals (including group evaluation) and \$180 for families or couples. Fee for service charges are as follows: **Individual** 30 min sessions are \$65 per ½ hr and \$95 per ½ hr for families or couples; 50-60 minute individual sessions are \$130 per 50-60 minutes and \$160 per 50-60 minutes for families or couples. **Group** therapy sessions can be one to two hrs in length. Therapeutic mental health, addiction, or dual diagnosis groups are \$75 per hr or your co-pay or deductible, if you are using insurance. Group rates for **non-therapeutic support groups** are \$60 for the initial evaluation and \$25 per hr paid monthly in advance (invoiced), as they are generally held weekly or bi-weekly, and require commitment, thus no refunds if you miss your group appointment. All groups, whether open or closed, require a minimum commitment which is posted for each group in order to establish rapport, trust, and cohesion. All payments are due at the time of service or you accept \$10 late fee and any other fees related including collection fees. Fees incurred by payment processors are also your responsibility for ex. NSF for credit card charge etc. Fees for services that require extensive time outside of therapy appointment such as court appearance, progress letters, extensive travel, and unscheduled calls lasting more than 15 minutes range from \$150 to \$200 per hr plus cost of extensive travel. **Sliding scale fees and pro-bono are considered individually at my sole discretion after completion of the application and substantial proof of hardship.**

Insurance: Should you wish to use an insurance policy for counseling services, please be advised to be certain of your benefits paying close attention to in-network and out-of-network (OON) benefits before making your appointment **as you are responsible for all payments despite disputes with insurance company.** I can assist you in filing claims and ascertaining information about your coverage but I can not be held liable for the accuracy of the information obtained and am not obligated to share with you as you are responsible for contacting your insurance company for all questions, concerns, or inquiries in regard to payment, reimbursement and covered services. I advise that this is done prior to your first appointment and that you get a reference number and contact name thus keeping record of the



communication. **You are fully responsible for full payment of all fees not covered by insurance such as NO SHOW and late cancellations which must be paid before continuing. **Thus is it policy that you retain a reliable credit card on file for such payments to be deducted. You are also responsible for any charge backs from the credit card company or your bank if the card is not valid or has insufficient funds at the time of the charge.** Occasionally, payment agreements are made and should be in writing if you have an outstanding balance but this is upon my discretion. Other forms of payment accepted are a most major credit cards, health savings cards and flex spending accounts and is expected at the time of service. Services may be delivered direct or through distance counseling using HIPAA compliant methods. Goals and length of treatment varies based on management of symptoms, therefore it is impossible to guarantee specific results regarding your treatment goals.

Termination or Missed/ Late Sessions: Either you or I may terminate the relationship at any time if it is felt that services are no longer beneficial or professional and therapeutic boundaries are blurred without resolve. Ideally, we will both agree when that time comes, at least one week in advance, thus scheduling a session for closure. Missing two appointments without contact calls for termination of future scheduled appointments and possible final termination. Resuming therapy is possible upon availability and appropriate fit. Each session is expected to begin and end at the appointed time, and is considered a full session even if you are late. **A full fee (your responsibility) is charged for no show appointments or cancellations with less than a 48 hr notice unless due to an emergency that is beyond your control (severe car accident, severe illness, etc.).** Work conflicts, childcare issues, double booking, or forgetting your appointment are not emergencies & you will be held responsible for the scheduled missed appointment fee to be paid before your next appointment. It is advised that you go online to the portal to reschedule before the 48-hr deadline. You may also call or email Richale to make aware of schedule changes at richale@caterrrfly.com or call me at the number above. If secure messaging is provided you may use to text me. It is recommended that you use at least 2 forms of notification for assurance that your communication is received at timestamped.

Your Medical Record/Protected Health Information (PHI): A record of your visit is made each time service is rendered from your health care provider. Any diagnosis that is rendered will become a permanent part of your record. This typically contains information regarding your symptoms, diagnosis, assessment, treatment plan, and treatment recommendations.

Confidentiality: I will make every effort to respect your privacy and confidentiality. Your private information will not be shared without your written consent. Please note the following circumstances where I cannot guarantee confidentiality legally or ethically: 1) suspected abuse or neglect of children, disabled or elderly adults; 2) imminent danger to self or others; 3) response to court orders 4) case consultation or supervision; and 5) defending claims brought by client against professional.

Social Media: It is considered a dual relationship to connect via social media. All social media friend requests will not be accepted. Please do not attempt to contact me through any social media platforms as boundaries are imperative to a therapeutic relationship.

Emergencies: I am not available 24hrs a day. For non-emergencies call 888-550-2804 to leave a voice mail. In the case of an emergency, you agree to call 911, the National Suicide Prevention Hotline at 800 273-8255, or your local mobile crisis facility and/or go to the nearest emergency room.



Filing Complaints: You are encouraged to discuss any concerns with me as it makes our work together more efficient and effective. However, should you feel I am in violation of any of these codes of ethics; you may file a complaint against me with the organization below. I abide by the ACA Code of Ethics.
<https://www.counseling.org/resources/aca-code-of-ethics.pdf>

North Carolina Board of Licensed Clinical Mental Health
Counselors,
PO Box 77819, Greensboro, NC 27417
Phone: 336-217-6007
Fax: 336-217-9450
[Email: LCMHCinfo@ncblpc.org](mailto:LCMHCinfo@ncblpc.org)

Consent to Treatment and Acknowledgment of Receipt:
Initial where applicable:

I consent to treatment & voluntarily agree to participate in all treatment
I am legally able to consent to treatment for the minor child.
I will, if my insurance does not cover, pay all final bills within 30 days of notice date.

By signing below, I consent to treatment and indicate that I have read, understood and agreed to these terms. I have received a copy and will abide by these guidelines:

Client Signature options:

Print, Sign, Upload & Submit:

Client Signature: _____ Date: _____

Or

Electronic signature through portal and submit. Your signature will be timestamped and dated.

Thank you for the opportunity to serve you and your family!